PRINTED: 07/07/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG W 000 INITIAL COMMENTS W 000 Surveyor: 17815 Lecensel on 1/1/08 A recertification survey was conducted from June 9, 2008 through June 12, 2008. The survey was initiated using the fundamental survey process. A GOVERNMENT OF THE DISTRICT OF COLUMBIA random sample of four clients was selected from a DEPARTMENT OF HEALTH resident population of eight women with various HEALTH REGULATION ADMINISTRATION disabilities. In addition, a focused review was 825 NORTH CAPITOL ST., N.E., 2ND FLOOR conducted of a fifth client's food and beverage WASHINGTON, D.C. 20002 texture and consistency. On June 9, 2008, at 6:27 PM, the facility was informed that Client #2's health and safety were at risk due to improper feeding technique. The Registered Nurse intervened immediately. Staff were retrained that evening and again on the following day. On June 12, 2008, at 3:15 PM, the survey was extended in the Condition of Health Care Services following deficiencies identified

The findings of the survey were based on observations, interviews with one individual's sister and another individual's court-appointed guardian. interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Conditions of Participation in Governing Body, Client Protections, Facility Staffing and Health Care Services.

during the review of client seizure records, lab

reports and neurology records.

483,410 GOVERNING BODY AND MANAGEMENT W 102

> The facility must ensure that specific governing body and management requirements are met.

W 102

(X6) DATE

Manus Branch

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE ans

1-17-03

ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other ds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2008 FORM APPROVED

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	COMPLET	
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W 102	Continued From pa	age 1	W 102	1 W 10Z, C	ontinueda	
	The facility's gover general operating of ensure client health	ning body failed to maintain direction over the facility to n and safety [Cross-refer to 9, W158 and W318].		Cross retered to WIOH, WI WISB and	we response will 318.	7.23.08 ongang
	facility's Governing	e systemic practices revealed the Body failed to adequately n a manner that would ensure om harm.				
W 104	483.410(a)(1) GO\	ERNING BODY	W 104	W104		
		y must exercise general policy, ting direction over the facility.				
	the governing body	rviews, and record verification refined to ensure that the facility sed general policy, and operating acility.		The state of the s		
	The findings includ	e:		,		,
	to develop policies sufficient number of monitored to preve management need	/111. The governing body failed and procedures to maintain a of staff to ensure that clients were nt injuries and address behavior is when transporting medically y in/off the van during medical		(1) Cross re respons Will	ference W159.	aliolos aliolos
	2. Cross Reference	e W159. The governing body	_		į	

TO:2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	DING		(X3) DATE SUI COMPLET	
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NAME OF PR	ROVIDER OR SUPPLIER			3	EET ADDRESS, CITY, STATE, ZIP CO 020 STANTON ROAD, SE VASHINGTON, DC 20020	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCE) TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
W 104	Professional (QMR was obtained as real Therapist (PT) one 3. Cross Reference failed to ensure that equipment had been accordance to their one client in the inv. 4. Cross Reference failed to ensure that provided a through that optimal health for one of one client. 5. Cross Reference failed to ensure that provided nursing seen needs of one of one 483.410(c)(1) CLIEThe facility must derecordkeeping systems.	the Qualified Mental Retardation P) ensured that a rolling walker accommended by the Physical of one client in the investigation. e W436. The Governing Body the recommended adaptive in provided and maintained in recommended needs for one of restigation. e W 322. The Governing Body the facility's medical services medical examination to ensure care and services were provided the investigation. e W 331. The governing body the facility's nursing staff ervices in accordance with the excilent in the investigation. NT RECORDS evelop and maintain a tem that documents the client's treatment, social information,			(3.) Reference these with 360 reference to W322 s. cross reference WIII This Standard is as evidenced by	nce W331	J.10.08
•	Surveyor: 17815 Based on record re failed to maintain a documented recent and reflected curre	view and interview, the facility record keeping system that health care services provided in thealth management care ne four clients in the sample.	·				
2014 0140 054	7/02-00) Provious Vomloos (Phooloto Supert ID: EL CO11			eille ID: 00C422	I	15. 0.540

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFICE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION.	(X3) DATE SU COMPLE	
		09G122	B. WING		06/1	2/2008
NAME OF PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP (3020 STANTON ROAD, SE WASHINGTON, DC 20020			
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Ŵ 111	#1's Health Manage reflected her custon. The review of unusurevealed that Client admission to the growth osteoporosis and a concern. The goal of the falls/injuries.	sing staff failed to ensure Client ement Care Plan (HMCP) n-molded shoes, as follows: ual incidents on June 9, 2008 #1 had sustained falls since her oup home on January 31, 2008. d May 23, 2008, documented history of fall as areas of was that the client would be free The HMCP did not, however, ruary 29, 2008 recommendation	W 11	Custom molde Tuly 10, 2008.	a snore or 1	7.10.08
	#2's HMCP reflected as follows: On June 11, 2008, a review of Client #2's that on February 14 discovered a "dark of the toe. The podiatrist is healed. On Februar the "fifth toe right for However, on April 1 for the next examina "There is tissue profinurse made aware oright foot" Subsect HMCP, updated Malevidence that nursing the subsection of the text of the t	sing staff failed to ensure Client d her podiatry treatment orders, at approximately 2:10 PM, a nurse progress notes revealed, 2008, the podiatrist had discoloration" on her fifth right recommended monitoring until by 18, 2008, a nurse wrote that not appears to be healing fine." 4, 2008, the podiatrist returned ation. The podiatrist wrote truding from fifth toe right foot, of tissue protruding from fifth toe quent review of the client's by 6, 2008, failed to show a staff had addressed what now curring health concern.	•	2. Podiatry treat r WILL be reviewed HMCP upclated Numering staff evidence the health conce addressed.	as needs. will show at the	6.25.08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		09G122	B. WING	06/12/2008
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION SH TAG REFERENCED TO THE APPROPRE	IOULD BE CROSS- COMPLETION
W 111	#5's HMCP reflected consistency orders, and consistency orders. On June 12, 2008 and physicinot reflect the order, facility nurses had so the survey. 4. Client #4 experiency January 14, 2008 who hospital. On June 12 records were reviewed Recent medical report alleged communicating were missing from her a. There was a consistency of the survey. b. Also on June 12, 2008, there was a consistency of the survey.	sing staff failed to ensure Client I food and beverage texture and as follows: 2. Client #5 had a pronounced une 10, 2008, at approximately ation nurse presented her with a ad difficulty drinking the water, the side, and water fell onto her ed liquids" was reflected on her MARs, and the Nutrition and assessments. However, Client ment Care Plan, dated February ian's orders for June 2008 did. There was no evidence that ought to clarify the order prior to need multiple seizures on sich led to her admission to a 2, 2008, the client's neurology ed, beginning at 9:15 AM. Its and documentation of ons with medical professionals	A) A. Nurse will follow the nurrologist a copy and verific Nuerologist usit b. Nurse will content to secure another thickense of the EEG rep RN will continue of the reviews and concerns as the	ovided ongoing on adherence of col. ion orders to reflect liquids. liquids. Arct Nuerologist orts. e to concluct address

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION	ON .	(XS) DATE SU COMPLET	
	·	09G122	B, WIN	G	 	06/1	2/2008
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, C 3020 STANTON I WASHINGTON	ROAD, SE		
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W 111	"report to follow." Tattached to the consof her medical record the EEG report. c. Client #4's record 2008, the neurologis levels of her anticon prescribed Tegretol, telephone order date that her primary can he ordered "Get all test." Lab reports in and Depakote were Keppra levels had no 2007. On June 12, PM, the RN stated to pharmacist and evel had all stated that K After examining the acknowledged that of professionals, report had not been docum #4's record. At the eafternoon, the DON stated. She did not, documentation of control of the c	The neurology clinic indicated here was no EEG report sultation form and further review ds failed to show evidence of ds indicated that on January 24, at ordered testing the serum vulsant medications. She was Depakote and Keppra. A led January 24, 2008 indicated e physician (PCP) concurred; anticonvulsant levels and LFT indicated that the client's Tegretol tested; however, her serum of been tested since October 3, 2008, at approximately 12:15 that the Director of Nursing, the intually the neurologist and PCP eppra levels were not needed client's chart, however, the RN conversations with those tedly clarifying the lab order, nented appropriately in Client, exit conference later that corroborated what the RN had	W	includ Depa does moni RN.	phyulsand the Tagre that requ thus, no ders is	eppro	6,13,08
W 120	OUTSIDE SOURCE	sure that outside services meet	W		tandard sudence	will be d by:	
	This STANDADD is	not met se evidenced hv.		Ensité ID: 00C422	1.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	A. BUILDING				(X3) DATE SURVEY COMPLETED		
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W 120	Surveyor: 17815 Based on observa review, the facility client's day progra for one of four clie The findings includ On June 9, 2008, program, between following deficient 1. Cross-refer to V approximately 11:0 staff at her day pro safety harness mu However, her right of the harness at t with the Qualified I (QMRP) on June 1 was known to inde under the harness review showed no addressed this iss addition, there was alleged habit of rei been addressed by 2. Cross-refer to V AM, Client #2 was day program that i gravy. The burger watery consistency review of her meal 2007, revealed tha	tions, staff interview, and record failed to effectively monitor each m to ensure that needs were met, ints in the sample. (Client #2) de: Client #2 was observed at her day 11:00 AM - 12:15 PM. The practices were observed: V436.3. On June 9, 2008, at 22 AM, Client #2's direct support ogram stated that her wheelchair is to be secured at all times. arm and shoulder were outside that time of observation. Interview Mental Retardation Professional 12, 2008 revealed that the client is pendently move her arm out from a Further interview and record evidence that the QMRP had use with the day program. In son evidence that the client's moving the safety harness had by her interdisciplinary team. V474. On June 9, 2008, at 11:31 presented a lunch plate at the included pureed beef burger with and gravy was of a thin and by Later that day, at 6:38 PM, time protocol, dated October 12, it she was to receive foods difiber, pudding consistency."	W		Cross to with the are pro- to war condi- to the	will con let voud le day unicale c	ince to the the formation of the formati	esponse with a point of the poi	7.22.08 ongoing
OBM CHE SE	27/02 00) Bravious Versions	Observation Francisco			DFC(S)	ens as	1 1409		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOR	MEDICARE	& MEDICAID	SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION. (X3) DATE SURVEY COMPLETED
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NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPLETION
W 120	pudding consistency that foods served at texture prescribed by 3. Cross-refer to W coughing during her on June 9, 2008. He that this was not una coughed frequently two day program nuthat neither was away during meals. Even coughing should have attention, day prograt to notify them. Ther	dated June 1, 2008 ("pureed to "). The facility failed to ensure the day program were of the y Client #2's physician. 127. Client #2 was observed lunch meal at her day program er direct support staff indicated usual; the client reportedly during meals. Interview with the rses a short time later revealed are that the client often coughed though the two nurses said her we been brought to their am direct support staff had failed to was no evidence that the ution had been monitored	W	o amap will ecordinate additional staff training as next on the monthing protocol and adherence to the preseribed chet plan.
W 122	Surveyor: 17815 The facility failed to procedures to ensure failed to ensure that were investigated th to ensure the safety aspiration [See W12] The effects of these the failure of the facility and the safety aspiration for the facility of the facility and the safety aspiration for the facility of the facility and the safety aspiration for the safety aspiration for the safety and the safety and the safety aspiration for the safety and the safety and the safety aspiration for the sa	implement effective policies and e Client #1's safety [See W149]; all injuries of unknown source oroughly [See W154]; and failed of clients who were at risk of	W -	This Standard will be met 9.25.08 as evidenced by: Reference response to W149 W154, and W127 and W194.

PRINTED: 07/07/2008

CENTERS FOR MEDICARE		, F	OMB NO. 0938-0	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
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I.D I	OVIDER OR SUPPLIER	3	REET ADDRESS, CITY STATE, ZIP CODE 8020 STANTON ROAD, SE WASHINGTON, DC 20020
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W 122 W 127	Continued From page 8 being. 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS	W 122 W 127	
	The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.		
-	This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure the health and safety of one client by making certain that all meals were served in accordance with prescribed dietary orders, for one of the four clients in the sample. (Client #2)		This Standard will be met as evidenced by
	A mealtime protocol had been developed to address Client #2's assessed risk of aspiration. Observations at the day program and in the home, however, revealed a failure to protect her health and safety. The mealtime protocol failed to provide clear, written instructions to ensure the client's health and safety. In addition, staff did not provide the meals in accordance with the protocol, as follows: 1. Client #2's mealtime protocol, dated October 12, 2007, did not provide clear, written instructions, as follows: a. On June 9, 2008, Client #2 was observed having lunch at her day program. At 11:44 AM, the client held her WonderFlo spout cup with her right hand	. :	1. Chent #2's mealtime protocol will be reviewed ongoing speech thempist and occupational therapist will be consulted as needed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	07/07/2008
FORM	APPROVED
OMB NO.	0938-0391

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W 127	client coughed repe moment, the staff per you have to rest, dri staff person placed head, pulled it forwal had tilted her head to not slow her drinking continued. The staff and stated "when she doesn't want to empty. At 11:54 Alwhile drinking some pace. When asked two direct support streplied yes.	ant at a very fast pace. The atedly while drinking. At one erson told her to "be careful ink a bit, and then rest." The her hand behind Client #2's and slightly, because the client backwards, hyperextending her ne verbal prompt, the client did a pace and the coughing f person turned to this surveyor he puts this cup in her mouth, release the cup" until it is at the client coughed repeatedly apple-cranberry juice at a fast if the client coughed often, the laff who were assisting at lunch of Client #2's mealtime protocol	W 1	to do noted uply a ctime add the a complete additional	during vare required monitoring consections for the consections of the	corrections neads and wed to the and and cems as low-up with ram staff o ensure that training amp will who will	ust.
	revealed the followind drinking Place the her to take sips of boundaries on how state on how state on instructions hyperextended neck fast pace. b. Client #2's mealtiful following: "feed her aspiration such as eyes." The protocol on how they should aspiration. At approximately 2:0 day program nurses staff to bring the clies	ng: "Staff should assist her with cup in her right hand allowing everage between bites and after The protocol did not further aff should assist her. There		ر از معوديم	md Phyreeded.	eicht headh	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		09G122	B. WIN	iG	: 11		06/12	2/2008
NAME OF PR	ROVIDER OR SUPPLIER			3	EET ADDRESS, CITY, S 020 STANTON ROAD VASHINGTON, DC), SE		
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W 127	day program case minformed of the obsecoughing. They wer support staff had indefrequent occurrence been told that the clithey both indicated unaware that she free The case managers group home for furth address her rapid drack. 2. Observations at the home revealed staff that were of the conscare physician and inprotocol, as follows: a. On June 9, 2008, presented her lunch was served, among burger with gravy. Thin and watery consindicated that she was added fiber, pudding consistent with her per 2008 ("pureed to pudden the client by staff to feed her the Boost Plus nutritional servers and the client protocol in t	anager were immediately erved fast drinking pace with erved that coughing was a. At the time, neither nurse had ent had coughed at lunch, that they were previously equently coughed during meals, stated that they would ask the er clarification on how to inking while hyperextending her the day program and in the did not feed Client #2 foods sistency ordered by the primary included in the mealtime. at 11:31 AM, Client #2 was plate at the day program. She other food items, pureed beef the burger and gravy was of a sistency. Her mealtime protocol as to receive foods "pureed with consistency." This was hysician's orders, dated June 1, dding consistency"). It should ent repeatedly refused attempts he food. She was presented it supplement instead.	W	127	2, Reference W127.1			
	were informed that C pudding consistency case manager stated	5 PM, two day program nurses client #2's food was not of a , as ordered. The nurses and a d that they would ensure that e future would be of the cy.			The section of the se		:	
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	- 1		COMPLETED
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NAME OF PR	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, S 3020 STANTON ROAL WASHINGTON, OC	D, SE	
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W 127	Continued From pa	ge 11	W	127		
	was observed mixing (pureed chicken, grotatoes) together glass. After the cling food mixture, she mattered Vanilla Boos it the consistency of the "pudding" consicare physician. In the minutes that several times while complete description At approximately 6 client's coughing to ther that the client's consistency.	B, at 6:21 PM, residential staffing Client #2's dinner foods reen beans and mashed into a wide-rimmed beverage ent ate a few spoonfuls of the efused to continue. The staff st Plus into the mixture, rendering if a thick soup. This too, was not istency ordered by the primary followed, Client #2 coughed being fed the mixture (see on in the paragraphs that follow). 27 PM, the surveyor brought the the RN's attention, and informed food had not been of pudding the did not give Client #2 her ribed WonderFlo spout cup, as		3. Referen	nce respons	se to
	On June 9, 2008, a person was observed food, in WonderFlo spout or observed pouring the from a wide-rimmeneck was hyperext. Without pausing, the pouring the mixture emptied the rest of which rendered the Once the feeding reand food came out	ed stirring Boost Plus into Client instead of using the prescribed up. The staff person was then the mixture into Client #2's mouth dispersion between the client sended and the client coughed are staff said "good girl" and kept into her mouth. The staff the Boost Plus into the glass, mixture to a soupy texture. Esumed, Client #2 coughed hard onto her bib. The staff said "I tit out" and continued	:			

TO:2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) 'PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	2 	(X3) DATE SU COMPLET	
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NAME OF PR	OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY 3020 STANTON RO WASHINGTON, D	AD, SE	É	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR)		ORRECTION HOULD BE CROSS: RIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	surveyor summoned RN, who had not be time, intervened immabout the client's Wo the staff said it was walked to the kitcher Plus, poured it into the client. The clien was now drinking the cup. No additional of the was now drinking the cup. No additional of the staff repeatedly of pudding consister and reviewed the prospect of the information of the staff regard and safety if/when a	approximately 6:27 PM, this in the nearby RN's attention. The en observing the meal at that nediately. She asked the staff conderFlo cup. While pointing, in the kitchen. The staff then in, opened another can of Boost the spout cup and returned to thad finished her dinner and esupplement from her spout coughing was observed. The the mealtime protocol, the er that the food had been pace, that the client had and that the food had not been now. The RN pulled staff aside cotocol with them. She then on with the Qualified Mental ional, who stated that they neir staff. It approximately 5:00 PM eal), the RN and the LPN on the indepth in-service training for ling the danger posed to health client aspirates food or	W 12	2.7			
W 149	to the clients' mealti		\8/ 4/		· · · · · · · · · · · · · · · · · · ·		
vv 149	The facility must dev	F TREATMENT OF CLIENTS relop and implement written ures that prohibit mistreatment, the client.	VV 14	9 WI49			

TO:2024429430

P.17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		09G122	B. WING		06/1	2/2008
NAME OF PR	OVIDER OR SUPPLIER		3	EET ADDRESS, CITY, STATE, ZIP CO 020 STANTON ROAD, SE VASHINGTON, DC 20020	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
W 149	This STANDARD is Surveyor: 12301 Based on interview failed to implement and safety of one of (Client #1) The findings include Client #1 was admit 2008. Her records i including "status pointerview with Qualit Professional (QMRF revealed that the client Plan (BSP) develop incorporated using a said she had review BSP at the time of a indicated that the client supervision during a This was verified as Individual Support Fouring the first sever admitted to the facilifialls, some of which revealed that the fact system to effectively sustaining injuries, and and incident report approximately one verboruary 7, 2008, and boarding a van and	and record review, the facility policies that ensured the health the four clients in the sample. Ited to the facility on January 31, indicated an history of falls, set fracture of the right humerus." Tied Mental Retardation P) on June 9, 2008, at 4:10 PM, ent's previous Behavior Supported by her former provider had one-on-one staffing. The QMRP ed with her staff the existing dmission. The QMRP further ent received one-on-one wake hours (6 AM - 10 PM). In accordance with her updated than (ISP), dated May 23, 2008. Tal months after Client #1 was try, she had four documented resulted in injuries. The survey cility had failed to implement a prevent Client #1 from as follows:	W 149	This Standard of as evidenced by Reference response W153 and W154	will be met	1.23.08 ovigoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDINI	PLE CONSTRUCTION) DATE SURVEY COMPLETED	
		09G122	B. WING	- 1-		06/1	2/2008	
NAME OF PR	OVIDER OR SUPPLIER		3	REET ADDRESS, CITY 1020 STANTON RO WASHINGTON, D	AD, SE	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR)		OORRECTION SHOULD BE CROSS- PRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	her seizure disorder sustaining injuries. implement "fall precinot specify or otherworecautions should in the specify or otherworecautions should in the sofa after a sustained slight swe reportedly saw her a unable to reach her sustained slight swe reportedly saw her a unable to reach her sustained slight swe reportedly saw her a unable to reach her sustained slight swe reportedly saw her a unable to reach her sustained slight swe reportedly saw her a unable to reach her sustained slight swe reported in a the sustained in the same sustained intervened an existing incident report failed intervened in accord no record of the Mar in the client's behavior had been in outlined in the BSP. It should be noted the should be noted the facility determined precautions might be incidents. 4. Review of in-servithat on March 21, 20 training to the direct.	ruary 1, 2008, stated that due to she had potential for The HMCP instructed staff to autions, daily," however, it did vise describe what fall be implemented. It documented that on February M, Client #1 fell while getting up wakening from a nap. She lling above her eyebrow. Staff s she was getting up but was	W 149	3) Cross Perview one se	ome Man Curren chedule	beger will tone on and provide	6.27.0.8 ongoing	
}				trainin	y as m	recled.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		09G122	B. WING		06/1:	2/2008
NAME OF PR		TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY	30	EET ADDRESS, CITY, STATE, ZIP COL 020 STANTON ROAD, SE VASHINGTON, DC 20020 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S	CORRECTION	(XS) COMPLETION
TAG		ENTIFYING INFORMATION)	TAG	REFERENCED TO THE APPROP		DATE
W 149	24, 2008, at 7:55 A Client #1's upper ris source of the injury 5. On April 2, 2008 her foot reportedly ambulating. The co dated April 6, 2008 PT training. In-sen- indicated that the P 2008, approximatel fall, and after she e May 1, 2008) that r 6. An incident repo 2008, at approxima heard making "loud Staff entered the be the floor, with an at- swollen right ankle. room revealed a right e client's injuries March 2008 BSP a (ISP), she was to re supervision during PM. When intervie acknowledged that time of her injuries. 7. On June 9, 2008 revealed that she w therapist (PT) on F assessment report, indicated that she " molded shoes as s	M, staff discovered a bruise to ght face, under the eye. The was not known. B, Client #1 fell on her knee after got caught on a chair while presponding investigation report, included a recommendation for vice training records, however, or provided training on May 17, by 6 weeks after the April 2, 2008 experienced yet another fall (onesulted in a sprained ankle. To the documented that on May 1, ately 8:00 AM, Client #1 was 1 vocalizations" in her bedroom, edroom and found her seated on prasion to her right knee, and a Evaluation at the emergency ght ankle sprain. The origin of were unknown. According to her and her Individual Support Plan eceive one-on-one staff awake hours between 6 AM - 10 wed further, the QMRP the client had been alone at the dated February 29, 2008, twould benefit from customon as possible secondary to ankles staff should be trained	W 149	Fall precautions a added to chient # and store training provided as need to track and real incidents and provide additions as needed. Incident Managerovide additions as needed. Incident Managerovide additions as needed. Incident report to incident report and the provide additions. - Incident report to incident report additions. - Incident report and provide additions. - Incident report and to incident report additions.	pernent le continue new out nicle feedback er will training uche but	7.23.08 ongani

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIF IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATÉ SÚRVEY COMPLÉTED	
		09G1	22	B. WING	-		06/12	2/2008
NAME OF PR	OVIDER OR SUPPLIER				30	EET ADDRESS, CITY, STATE, ZIP CODE 120 STANTON ROAD, SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCE BE PRECEDED BY FULL TIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
W 149	Continued From pag when she flops onto that he had discusse clinical plans with the direct support staff at team members on Figure 9, 2008, intervithat the PT recommer achieved timely, as fall as a Staff in-service trae. a) Staff in-service trae PT trained staff on Mither the assessment and was admitted. b) The client remained She was scheduled 2008, 3 1/2 months a should be noted that molded shoes was donoths after the PT with the QMRP. 8. Cross-refer to Watthe time that Client were discovered on to implement the face policy to ensure time that the QMRP and I immediately of all enthat incident reports end of the shift. How and the facility's Directively. In summary, the Jun QMRP revealed that	the floor." The PT d his recommendate QMRP, House M not the relevant interpretations had not be produced by the conditions had not be completed by 17, 2008, 2 1/2 aimost 4 1/2 montaiter the PT assess the 719A form for ated May 19, 2008 discussed the need by reporting. The product of Residential transporting of the product of Residential and 24 hours later, 29 PM and 2:50 Plee 9, 2008 interview of 9, 2008	ations and anager, erdisciplinary However, on revealed been atted that the months after has after she ded shoes. To no July 10, sment. It the customer than 2 d for shoes are on duty at nown origin 20 AM, failed agement bolicy states notified also stated ed before the State agency Services on May 2, M,	W 1		8. Cross reference W	153	
							,	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
·						·		
	<u></u>	<u> </u>	09G122	B. WING		06/	12/2008	
NAME OF PR	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFL BE PRECEDED BY NTIFYING INFORM	FULL REGULATORY	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE	
W 149	Continued From page required close super injuries due to falls we however, review of it she had experienced 2008 - May 1, 2008, one staff assigned betwee 3 injuries documented in March 20 origin. In addition, the prescribed custom materials and the survey. There was minimal to the survey of the survey implemented measures afety.	vision and hat then she was neident report four falls bet Even though etween 6 AM nented since 08, 2 of which e client remainded shoes of evidence the	admitted. Is revealed that Is revealed t	W 14	9			
W 153	483.420(d)(2) STAFI The facility must ensing mistreatment, neglect of unknown source, administrator or to ot State law through es	ure that all all t or abuse, as are reported in her officials in	egations of s well as injuries mmediately to the accordance with	W 15	This Standard will as ouldenced by:	be met	7.14.08 ongoing	
	Surveyor: 17815 Based on interview a staff failed to consist origin to the administ within the required tir. The finding includes: According to an incid the primary care physisend Client #1 to an corresponding invest she was seen at the morning (May 1, 2006)	nd record verently report in return and outs frame. ent report data ician instruct mergency report ER at 9:30 AN	ed May 1, 2008, ed the nurse to om. The indicated that to the same					

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Event ID:FLC011

Facility ID: 09G122

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		09G122	B. WING		06/12/2008
NAME OF PE	OVIDER OR SUPPLIÉR		;	REET ADDRESS, CITY, STATE, ZIP CODE 8020 STANTON ROAD, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NT FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS- COMPLÉTION
W 153	the incident report, I written report was prollowing day (May 2 incident report, the C Professional (QMRF facility's Director of I notified more than 2 (at 8:00 AM, 2:29 Pl The facility's incident the QMRP and Dire immediately of all enthat incident reports end of the shift. The implemented their p timely notification of 483.420(d)(3) STAF	nowever, revealed that the repared at 2:00 PM on the 2, 2008). According to the Qualified Mental Retardation P), State agency and the Residential Services were 4 hours later, on May 2, 2008 M and 2:50 PM, respectively). It management policy states that ctor should be notified mergencies and it also states should be completed before the ere was no evidence that staff olicies, as written, to ensure this incident.	W 153	W153, continued Reference resp to W149.8	onse 7.14.08 ongoing
	Surveyor: 17815 Based on interview of ailed to thoroughly neglect, for one of the facility. (Client #1) The finding includes Interview with Qualify Professional (QMRF 4:10 PM, revealed to the facility on Janual and her current Beh	fied Mental Retardation P) on June 9, 2008, beginning at the client #1 was admitted to ry 31, 2008. Both her previous avior Support Plans (BSPs) of one-on-one staffing during		This Standard will as evidenced by: • Reference respons 1449.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			VIDER/SUPPLIER/CLIA (X2) MULTI TIFICAȚION NUMBER: A. BUILDIN		IPLE CONSTRUCTION (X3) DATE COM		
			09G122	B. WING		06/12	2/2008
NAME OF PE	ROVIDER OR SUPPLIER		i	s	TREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEF BE PRECEDED B TIFYING INFORM	Y FULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
W 154	Continued From pag AM - 10 PM. This wa accordance with her Plan (ISP), dated Ma On June 9, 2008, an that on May 1, 2008, Client #1 was heard her bedroom. Staff of her seated on the flo knee, and a swollen emergency room rev incident report did no sustained the injuries QMRP acknowledge at the time of her inju- Later that afternoon, investigation report, of that even though Clie on-one supervision, investigation report for	updated last updated indiversed the bigon architecture of the bigon architecture of the bigon furth and that Client ries. Teview of the bigon furth of that May 5, and the bigon furth and the bigon furth of the bigon furth of the bigon furth architecture	vidual Support ort documented ately 8:00 AM, vocalizations" in edroom and found orasion to her right evaluation at the ankle sprain. The w the client er interview, the #1 had been alone corresponding 2008, revealed prescribed one- 5:00 AM, the	W 15	additional staff tro additional staff tro on incident reporting procedures, one-on duties and responsi with emphasizes monitoring and o and amount to manage continue to manifor interactions and in to further ensure a with this standard.	oversyld er will ov staff derventions ompliance	
W 158	The facility must ensire requirements are me This CONDITION is Surveyor: 17815. Based on observation review, the facility fail and safety [Cross-ref facility's Qualified Me (QMRP) failed to efferment the needs of its and the facility failed	re that spec is, interviews ed to ensure er to W127 a ntal Retardat ctively coord clients [Cros	and record clients' health nd W149]; the tion Professional inate services to s-refer to W159];	W 15	Reference response to W127 and W149 a W159.	nd	7,23:08 Onganey

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SU COMPLE					
,			; D9G122	B. WIN	G	06/1	2/2008
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 3020 STANTON ROAD, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ITEMENT OF DEFI BE PRECEDED BY ITIFYING INFORM	FULL REGULATORY	ID PREFI TAG		HOULD BE CROSS-	(X5) COMPLETION DATE
W 158	demonstrated compo clients' mealtime pro The effects of these the failure of the faci adequately trained s	etency in impl tocols [Cross systemic prace lity to ensure taff, to ensure	refer to W194]. tices results in the availability of	W.	158		
. W 159	safety and well being 483.430(a) QUALIFI PROFESSIONAL		RETARDATION	w ·	159 W159		
	Each client's active t integrated, coordinat mental retardation p	ed and monit					
	This STANIDARD is Surveyor: 17815 Based on observation verification, the Qual Professional (QMRP monitor services for in the facility. (Client	n, staff intervi ified Mental R) failed to coo four of the eig	ew and record etardation rdinate and ht clients residing		This Handard well as endemed by	l be met	
1	The findings include: 1. Cross-refer to W1 ensure that residenti trained to effectively Clients #2, #3 and #8	94. The QMi al and day pro and compete	gram staff were htly implement		1. Cross reference	e respinal	7.24.08 organa
	2. Cross-refer to W2 ensure that Client #4 April 13, 2008, provid on how to assist her	's mealtime p led staff with	rotocol, dated clear instructions		2 Cross reference to W240	. nesponse	
	3. Cross-refer to W1 ensure that day prog that were pureed to a	ram staff fed	Client #2 foods		3. Cross reference to WIZD	ce nesponal	

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Facility ID: 09G122

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STATEMENT OF DÉFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,				A. BUILDING	<u> </u>		
		:	09G122	B. WING		06/1	2/2008
NAME OF PE	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
IDI					8020 STANTON ROAD, SE		
	· <u></u>			l	WASHINGTON, DC 20020		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEF BE PRECEDED B TIFYING INFORM	Y FULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
W 159	Continued From pag	ė 21		W 159			
	accordance with her the QMRP failed to e monitored her for sig client's wheelchair so at all times.	nsure that dans of aspiration	ay program staff on and kept the properly secured		A) frace reference nes		
	4. Cross-refer to Wathickened liquids was mealtime protocol, N Speech/ Language A her Health Managen 12, 2008 and her phidid not reflect the ordinat the QMRP had sto the survey.	reflected on ARs, and he ssessments, ent Care Pla sician's orde ler. There wa	Client #5's r Nutrition and it was noted that n, dated February rs for June 2008 as no evidence	·	4) Cross reference nes		
25 K	5. Cross-refer to W1 ensure timely support ensure Client #1's sareports revealed that numerous falls betwee (January 31, 2008) as the had a one-on-on-10 PM, there were her Behavior Support 2008. Other injuries addition, the client reporthopedic shoes more February 29, 2008 refereigned.	ts and service fety. Review she had expend the date of	es necessary to of incident erienced of admission 08. Even though ned between 6 AM urnented since odated in March I in February. In out her prescribed onths after the PT's		6) Cross reference No to W149.		1.7308 ongany
	6. The QMRP failed communication syste Client #4's day progr On June 9, 2008, at support staff at Clien that the client had be her wheelchair for the	to establish am between them, as followed	an effective ne home and s: / 12:00 PM, direct gram reported	•	Home Manager/and implement an eff monitoring proce ensure that cher is provided at the sling at all time	ective ess to	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER IDENTIFICA	SUPPLIER/CLIA TION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
			09G122	B, WIN	'G		06/1:	2/2008 _ ·
NAME OF PR	OVIDER OR SUPPLIER				3	EET ADDRESS, CITY, STATE, ZIP CODE 020 STANTON ROAD, SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEF BE PRECEDED E NTIFYING INFORI	Y FULL REGULATORY	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
W 159	continued From page three weeks. Obsers no sling on the wheels further indicated that the sling was needed wheelchair. The QN interviewed in the house of the dissue between the dissue of the was previously that the transfer slin weeks. She stated the wheelchair prior further discussion, slin was no checklist or distributed which she could verificately.	vations reveal chair at that the client wad for safe trail IRP and home on June that this had ay program a said she that it was the y to ensure the departure; he acknowled ther system	moment. Staff as heavy and that his fers from her he manager were 12, 2008, at 10:55 been an ongoing and the home; ught that the issue view revealed that Client #4 did not beelchair in recent morning shift hat the sling was in however, upon aged that there established by	w	159	W159, continued Additional staff train will be provided as a to ensure the establishment of the continues are implessed.	ning leeded olished emented	
W 194	483.430(e)(4) STAFI Staff must be able to techniques necessar program plans for earesponsible. This STANIDARD is Surveyor: 17815 Based on observation verification, staff faile in implementing clien of the eight clients re #2, #3 and #5)	demonstrate y to impleme ch client for not met as a n, interview e d to demons its' feeding p	e the skills and int the individual whom they are videnced by and record trate competency rotocols, for three	W	194	This Standard will be mot as evidenced by:	2	
	The findings include: 1. The facility failed		iff displayed					

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Facility ID: 09G122

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIP	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
_			A. E	BUILDING			
	.	09G122	В. V	WING		06/1:	2/2008
NAME OF PE	OVIDER OR SUPPLIER	į į	-	ŞTR	EET ADDRESS, CITY, STATE, ZIP CODE		
IDI		:		30	020 STANTON ROAD, SE		
וטו		<u>'</u> .		w	ASHINGTON, DC 20020		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID.	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGUL	ATORY PR	REFIX	(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	(X5) COMPLETION DATE
TAG	OR LSC IDEI	ITIFYING INFORMATION)	'	AG	REFERENCED TO THE APPROPRIATE DE	FICIENCY)	DAIL
		<u> </u>					
W 194	Continued From pag	ė 23	1 1	N 194	W194 continued		
	competency in imple	menting Client #2's diet	order,				
	as follows:	1				-	
		5	\$		a. Additional staff train	> not	
		Client #2 was observed		1	will be provided to e	Marines T	
		iram, beginning at 11:31			Mill be himided to a	1004	
		reed beef burger with g			adherence to the m	eal	7.24.08
		watery texture. At 1:3 ne protocol, dated Octob					1 .
		ier foods should be pure			protocol.		OMODINA
	"pudding consistency	." This was consistent	with her				
		ated June 1, 2008. Sign			distriction of the second		
		ealtime protocol indicate			b. Reference respons	ie to	
	day program staff ha	d received training 6 mo			W120.1 and 2	, 0	
	earlier, on Novembe	29, 2007.				ļ	
		i :	+		a Additional staff tra	WWY	
		at 6:21 PM, Client #2 w	as		a Additional STATE I'm	,,,,,,,,	
1		Residential staff was			will be provided for	the	1
		dinner foods (pureed ch			nursing and ATS st	enff	
		shed potatoes) together erage glass, After the			musing and At 3 3	, , , , , , , , , , , , , , , , , , , 	
		the food mixture, the s			on adherence to m	nealtime	
		Boost Plus into the mixt					
		stency of a thick soup.			protocoliz food consi	aci ciez	
	previously noted, her	food was to be pureed					
	pudding consistency				m @MRP/Home Manage	er will	
		i i			w control from the sand us		
	Because Client #2 w	as observed to cough di	uring		continue to conduc		
		, the RN was informed b			routine meal moi	VITOLING	•
		had been presented a			absorbetions, ovo	vicke_	
		oughed repeatedly and n of pudding consistence			feedback and in	struction	
		and reviewed the proto		ļ	tobalocie and in		
		ed the information with		į	as needed to em	SULTY.	
		rdation Professional, w			ongoing compliant this standard.	ice wy	
	stated that they woul	d retrain all of their staff	.	}	han bound sall	Ť	
		i ,			Alla alminor		
	On June 10, 2008, at	approximately 5:00 PM					
			1			· «,	
		1					
		<u> </u>					ł

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
٠. دمي			(09G122	B. WIN	IG		904	0/0000
NAME OF D			<u> </u>				1 06/1	2/2008
ID I	ROVIDER OR SUPPLIER				3	EET ADDRESS, CITY, STATE, ZIP CODE 020 STANTON ROAD, SE VASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFI BE PRECEDED BY ITIFYING INFORM	FULL REGULATORY	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
W 194	Continued From pag (before the dinner moduty provided a more all of the staff regard and safety if/when a beverage and therefore to the clients' mealting 2008, staff in-services reviewed, beginning training on clients' mosurvey, had been done Even though there has provided, the observation of the continuation of the continuation of the continuation of Client #5 and services and the continuation of Client #5 and services and servic	eal), the RN as indepth in-sing the danged dient aspiratore, the impore protocols. It in a 10:00 AM. ealtime protocumented on a 10:00 AM. ealtime en a 10:00 AM. The was to reconsistency of her record seesment, of her tonged en a 10:00 AM. ealtime to her tonged en a 10:00 AM. There is and nectar-tiple et a 10:00 AM. There is to her tonged en a 10:00 AM. There is to her tonged en a 10:00 AM. There is to her tonged en a 10:00 AM.	ervice training for posed to health as food or tance of adhering On June 11, ords were. The most recent cols, prior to this March 21, 2008. The training aff interviews training had been to the color of the color o	W		2. Cross reference reato WIII. • RN will continue to Conduct routine during meal times admit to further ensure Compliance with standard. Nursing staff will required to attendard. Training.	o doservation and nistration onspiring this	- -

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A, BUILDING	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		09G122	B. WING		06/1	2/2008
NAME OF PR	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 8020 STANTON ROAD, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
W 194 W 240	feeding orders. On were observed givin prescribed by the PO	two occasions, different nurses g the client less water than was	W 194 W 240	W 240		
		am plan must describe relevant oort the individual toward		This Stand and well as endemed low.	Lbe met	
	Based on observation review, the facility far protocols provided c	on, interviews and record illed to ensure that mealtime lear, written instructions to staff ents, for one of the four clients ints #4)				
. :	did not define or des staff were to use the as follows: On June 9, 2008, a cobserved spoon feed that day, at 6:10 PM. Retardation Professi assisting the client withe spoon in the client. The client held the proceeded with provassistance through minterviewed on June QMRP confirmed that over hand assistance acknowledged that the	protocol, dated April 13, 2008 cribe with sufficient detail how prescribed unbreakable spoon, day program staff person was ding Client #4 her lunch. Later, the Qualified Mental onal (QMRP) was observed with dinner. The QMRP placed in hand and asked her to hold e spoon lightly and the QMRP iding hand over hand most of the meal. When 12, 2008, at 11:25 AM, the at Client #4 should receive hand a during meals. She his was not indicated on the When discussing the day		A Reference response The meal time period to a updated to a specific information to assistance needs meal times. The information to day program staff conduct training a	e that protocols reflect ation on opports/ ed during a copy of other and	7.22.08 ongang

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	COMPLETED
		09G122	B, WING	4	06/12/2008
NAME OF PE	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, \$TATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY ML	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	IÒ PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	IOULD BE CROSS- COMPLETION
W 240	program staff short Client #4 to particit because it had be She further indicate	age 26 ons, the QMRP stated that day all have known to encourage pate with hand over hand support en a training objective in the past, ted that she had not observed the am during lunchtime.	W 2	40 W 240, continued	•
W 249	As soon as the int formulated a client client must receive program consisting services in sufficie	erdisciplinary team has t's individual program plan, each a continuous active treatment g of needed interventions and int number and frequency to rement of the objectives identified ogram plan.	W 2-	49 W249	
	Surveyor: 17815 Based on observa the facility failed to continuous active needed interventio the sample. (Clier The findings include Client #1 was adm Behavior Support by her former provisupervision. Her r incorporated one-cand 10 PM. The Behaviors: physical	itted on January 31, 2008 with a Plan (BSP) that was developed ider. It included one-on-one new BSP, dated March 2008 also on-one staffing, between 6 AM ISP listed the following targeted il aggression, self-injury (including ing herself to the floor");		This Standard will as evidenced by	l be met

PRINTED:	07/07/2008
FORM A	APPROVED
OMB NO	0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		09G122	B. WING	-	06/1:	2/2008
NAME OF PE	ROVIDER OR SUPPLIER		3	EET ADDRESS, CITY, STATE, ZIP COD 020 STANTON ROAD, SE VASHINGTON, DC 20020	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
W 249	nutritional recomme The BSP said staff's targeted behaviors. staff implemented C (BSP), as follows: 1. The psychologist #1's annual psychologist 22, 2008: "Data for Further, data for Ma 2. An incident repor PM, documented the having her hair wash reopened an existing incident report failed intervened in accord of the tantrum. Ther available to verify pr BSP. The correspon May 5, 2008, failed to response to the tantrum.	ge 27 g food in excess of her notations and non-compliance, should record all incidents of There was no evidence that lient #1's Behavior Support Plan wrote the following in Client ogical assessment, dated Mayor February is not available, rch and April is also missing" It, dated March 3, 2008, at 6:15 at Client #1 had a tantrum while ned. She fell to the floor and g sore on her knee. The to indicate how or whether staff ance with the plan, at the time is was no behavioral data oper implementation of the noting investigation report, dated o indicate whether the staff's rum behavior had been in stegies outlined in the BSP.	W 249	WZ49, continue Reference response and W149.		7.23.08 ongoing
W 252	Data relative to accompedition of specified in client incommented must be documented. This STANDARD is Surveyor: 17815 Based on interview a	BRAM DOCUMENTATION Implishment of the criteria dividual program plan objectives d in measurable terms. Indicate the program plan objectives and record review, the facility ehavior data in accordance		W252 This standard wi as ovidenced by:	U be met	

TO:2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G122	B. WING		06/12/2008	
NAME OF PR	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP COD 8020 STANTON ROAD, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS- COMPLETE	ON
W 252	with the Behavior St	upport Plan (BSP) for one of four) with a BSP (Client #1).	W 252	W252, continued	•	
	2008. Interview with Professional (QMRF the client's previous provider had incorported staffing. The behavior on February 4, 2008. March 2008. The Bushaviors: physical "deliberately throwin tantrums, attempts the excess of her nutritic compliance. The Bushavior of targeted not performed, acconserview of Client #1" assessment, dated If following: "Data for Further, data for Matheway of the floor and reopen knee. The incident whether staff had intime of the tantrum. not reflect the March	tited to the facility on January 31, h Qualified Mental Retardation P) on June 9, 2008 revealed that a BSP developed by her former orated using one-on-one vior specialist observed the client 3 and issued a new BSP, dated as issued a new BSP, dated as issued a new BSP, dated aggression, self-injury (including a herself to the floor"); to abscond, securing food in onal recommendations and non-SP said staff should record all d behaviors. This, however, was ording to the psychologist. It is annual psychological May 22, 2008 revealed the or February is not available. In and April is also missing" Intreport, dated March 3, 2008, anted that Client #1 had a g her hair washed. She fell to ned an existing sore on her report failed to indicate how or tervened appropriately at the The client's behavior data did in 3, 2008 incident. The sinterviewed on June 11,		Client #15 behavior documentation has filed. amer will continue documentation as of the kehavior signal address as they arise.	to monitor No implementation	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF LIEVETH YIND HOMINIA SELATOES
ENTERS FOR	MEDICARE & MEDICAID SERVICES

W 252 Continued From page 29 2008, at approximately 12:35 PM, she stated that the data had been in the facility; however, the behavior specialist had not requested it. Additional Information was not provided before the survey ended. W 318 W 318		F CORRECTION	IDENTIFICATION NUMBER:	A. BUILOIN	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
ID I SUMMARY STATEMENT OF DEFICIENCES ID I (A) SUMMARY STATEMENT OF DEFICIENCES WASHINGTON, DC 20020 PREFIX GEACH OBERDIANY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 252 Continued From page 29 2008, at approximately 12:35 PM, she stated that the data had been in the facility; however, the behavior specialist had not requested it. Additional information was not provided before the survey ended. W 318 W 318 W 318 The facility must ensure that specific health care services requirements are met. W 318 Surveyor: 17815 Based on observation, interviews, and record review, the facility failed to ensure that staff in the home and at day program demonstrated competency in implementing clients' mealtime protocols [Cross-refer to W322]; failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross-refer to W332]; and, failed to ensure timely medical follow-up and referrals to ensure health services were provided to meet the needs of the clients [Cross-refer to W338]. The results of these systemic practices results in			09G122	B. WING_		06/12/2	800
PREFIX TAG PREFIX TAG CEACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG PREFIX TAG CEACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG REPERRENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REPERRENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REPERRENCED TO THE APPROPRIATE DEFICIENCY) W 252 2008, at approximately 12:35 PM, she stated that the data had been in the facility; however, the behavior specialist had not requested it. Additional information was not provided before the survey ended. W 318 Thus Standard will be methan out requested by: W 318 W		ROVIDER OR SUPPLIER			3020 STANTON ROAD, SE		
2008, at approximately 12:35 PM, she stated that the data had been in the facility; however, the behavior specialist had not requested it. Additional information was not provided before the survey ended. W 318 483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. W 318 518 Thub Standard will be met as evidenced by: Surveyor: 17815 Based on observation, interviews, and record review, the facility falled to ensure that staff in the home and at day program demonstrated competency in implementing clients' mealtime protocols [Cross-refer to W127 and W194]; failed to provide preventive and general health care services to meet the needs of the clients [Cross-refer to W322]; failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross-refer to W331]; and, failed to ensure timely medical follow-up and referrals to ensure health services were provided to meet the needs of the clients [Cross-refer to W338]. The results of these systemic practices results in	PRÉFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SH	łOULD BE CROSS- □	(X5) OMPLETION DATE
The facility must ensure that specific health care services requirements are met. This Standard will be met as evidenced by: This Standard will be met as evidence by: This Standard will be met as evidence by: The Standard will be met as evidence by: This Standard will be met as evidence by: This Standard will be met as evidence by: The results of these systemic practices results in	to .	2008, at approximathe data had been behavior specialist information was no ended.	ately 12:35 PM, she stated that in the facility; however, the had not requested it. Additional of provided before the survey				
Based on observation, interviews, and record review, the facility falled to ensure that staff in the home and at day program demonstrated competency in implementing clients' mealtime protocols [Cross-refer to W127 and W194]; failed to provide preventive and general health care services to meet the needs of the clients [Cross-refer to W322]; failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross-refer to W331]; and, failed to ensure timely medical follow-up and referrals to ensure health services were provided to meet the needs of the clients [Cross-refer to W338]. The results of these systemic practices results in		The facility must en	sure that specific health care		This Standard will as evidenced by:	7	23/08 ngoing
The results of these systemic practices results in		Based on observative review, the facility thome and at day proceed protocols [Cross-reprovide preventive to meet the needs (W322]; failed to estable to be clients' health and (W331]; and, failed up and referrals to provided to meet the	falled to ensure that staff in the rogram demonstrated lementing clients' mealtime fer to W127 and W194]; failed to and general health care services of the clients [Cross-refer to tablish systems to ensure that ere provided in accordance with safety needs [Cross-refer to to ensure timely medical followensure health services were		W194 and W32Z	Í	
health care services.		the demonstrated fa	ailure of the facility to provide	·	1		
W 322 483.460(a)(3) PHYSICIAN SERVICES W 322 W 322 The facility must provide or obtain preventive and general medical care.	W 322	The facility must pro	ovide or obtain preventive and	W 322	W(323		
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FLC011 Eachby ID: 08C122	08/4 01/0 05	7/00 00) P					

TO:2024429430

P.34

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G122	B. WING		06/	12/2008
NAME OF PR	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP COL 1020 STANTON ROAD, SE WASHINGTON, IDÇ 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROPRIES	SHOULD BE CROSS-	(X5) COMPLETION DATE
W 322	This STANDARD is Surveyor: 17815 Based on observation review, the facility fa	on, staff interview and record ailed to provide preventive and e for three of the four clients in s #2, #3 and #4)	W 322	W322, continued This standard was evidenced by		
	1. Incident reports i ongoing seizure acti referrals to hospital observation and ass client was taken to a 2008 after experient that evening. The creviewed, beginning She was prescribed medications; Tegret Depakote was adde 2007. The following identified:	ndicated that Client #4 had vity, some of which led to emergency rooms for further essment. For example, the a hospital ER on January 14, cing 3 back-to-back seizures lient's medical records were on June 11, 2008 at 5:08 PM. the following anticonvulsant ol, Keppra and Depakote; the d to her regimen on August 8, deficient practices were				650
	Client #4 for serum and in accordance we For example, on Jar increased her daily or requested updated a January 24, 2008, the concurred and order Her Tegretol and Deuntil 6 weeks later (Nabs performed on March 27 requested updated livels. On March 27 requested updated livels.	338.4. The facility failed to referenticonvulsant testing timely with physician's orders (POs). Invary 24, 2008 the neurologist dosage of Depakote and anticonvulsant levels. Also on the primary care physician (PCP) and labs for anticonvulsants. Spakote levels were not tested warch 11, 2008). Results of farch 11, 2008 and March 26, mued sub-therapeutic Depakote 7, 2008, the neurologist abs. Client #4's serum d on May 19, 2008, more than 7 in.		a. Cross-refer	N 338.4	onclared

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION :	(X3) DATE SUI COMPLET	
		09G122	B. WING_		06/1	2/2008
NAME OF PE	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COE 3020 STANTON ROAD, SE WASHINGTON, DC 20020	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES SE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	COMPLETION DATE
W 322	[Note: The neurolog function tests on Jar performed, however 19, 2008.] b. The facility did not seen by the neurolog frequency. On Janu prescribed an increat to have labs drawn at 4, 2008. The labs with she did not return for appointment. She did not return for appointment. She did which time the neurolog Depakote dosage agrecords indicated 8 seizures in February March 2008.] c. Cross-refer to 11 Client #4's records in neurological test resides. The facility failed tracking system to sufficient with the seizure activity. At 5:08 PM, review of infeport forms revealed seizures each month wrote the following of consultation form: "	pist and PCP also ordered liver huary 24, 2008. This was not until 4 months later, on May of the ensure that Client #4 was gist at the recommended ary 24, 2008, the neurologist use in her Depakote. She was and return to the clinic on March ere not scheduled timely and the March 4, 2008 id return on March 27, 2008, at ologist noted that her labs sub-therapeutic Depakote gist increased her daily gain. [Note: Her seizure elizures in January 2008, 5, 2008 and 3 more seizures in 1.3. The facility failed to ensure included the results of all recent ults. It implement an effective summarize the extent of Client as follows: If a Seizure Summary Chart #4 had experienced 2 seizures 1 seizure in November 2007. Individual Seizure Observation at that she had experienced 3 in addition, the neurologist in an October 30, 2007. Is doing well, no seizures"	W 322	c. Cross-refer to d. Nurses one respo reviewing and s the information Au discrepencies addressed. RN will continue rowning tite aud ensure rongoing with this star	nsible for summarizing, n. s will be to conduct luts to compliance	J.18:08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
			09G122	B. WING	: <u></u>	06/12	/2008		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETION DATE		
	W 322	accurately reflected the number of seizures occurring. 2. The facility also failed to refer Client #2 for serum anticonvulsant testing timely and in accordance with physician's orders (POs). Her POs reflected ongoing lab orders to obtain serum Tegretol levels every 3 months. On June 11, 2008, beginning at 11:02 AM, review of lab reports revealed a 6-month gap in testing, between August 16, 2007 and February 14, 2008. Her seizure records indicated she was taken to an emergency room on September 30, 2007 after a seizure. She experienced another seizure in November 2007 as well. 3. Even though Client #2 was at risk of aspiration during meals, there was no evidence that the medical team had effectively monitored the implementation of her mealtime protocol, to ensure her health and safety. Cross-refer to W127, W331.1. Client #2's mealtime protocol, dated October 12, 2007, and her ongoing POs, prescribed foods pureed to a pudding consistency. Staff also were instructed to "monitor for signs" of aspiration. During the survey, staff at the day program and in the home were observed feeding her foods that were not of a pudding consistency. Client #2 was observed coughing during her meals at the day program and at home.		W 322	3. Cross-refer W12 Reference respo Nurse and ampl routine visits to to concluct mon of meals.	nse to W120. to conduct day program			
		Staff in both locations reported that it was not unusual for her to cough. Nursing staff, however, in both locations stated they were unaware of her coughing. Review of the mealtime protocol revealed no clear instructions for staff to follow if/when they observed her coughing.		Addutional state will be provided will be provided the residential of program sites that not limited	at both and day o include				

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図012/025 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/03/2008 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G122 NAME OF PROVIDER OR SUPPLIER 06/12/2008 STREET ADDRESS, CITY, STATE, ZIP CODE IDI 3020 STANTON ROAD, SE WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID ΙÞ PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY W 322 Continued From page 33 W 322 administered a half can of Isosource. Throughout 322, continued... the process, including flushes before and after each supplement and food source, the nurse adherence to C-tube/ medication feeding. used a total of 250 ml of water. He stated that the 250 ml was a minimum, and that the client was not on a fluid restriction. 7.18.08 RN will provide additional ongoind On June 10, 2008, beginning at 12:36 PM, Client training on c-tupe #3's physician's orders (POs) were reviewed to medication and feeding verify the medication pass and tube-feeding procedures in accordance to physician orders. process. The June 2008 POs reflected three separate and distinct feeding orders, as follows: "Free water flushes with 250 ml 4 times daily after RN will conduct routine each feeding..." observations of q-tube feeding to ensure ongoing compliance with this standard. "Flush tube with 15 ml water before and after each medication and 5 ml water between each medication every shift." "2 scoops Beneprotein three times daily via G-tube..." Both nurses had begun the process by securing 250 ml, which they administered at various times throughout the feeding process. Both nurses

failed to implement the second order (flushing with 15 ml between each medication). The afternoon nurse failed to administer 250 ml after the feeding and the morning nurse had used a portion of the 250 ml for dissolving the protein powder.

The facility's RN was interviewed on June 10. 2008, beginning at approximately 12:55 PM. She stated that Client #3's POs had been written to reflect the what the nutritionist had recommended. The RN stated that she would seek clarification of the orders with the nutritionist. The nutritionist was in the facility the next day. At 9:53 AM, the RN said that she had just spoken

Event ID: FLC011

Facility IO: 09G122

PRINTED: 07/07/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING B. WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE IDI WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG TAG W 322 Continued From page 34 W 322 Both nurses had begun the process by securing 250 ml, which they administered at various times throughout the feeding process. Both nurses failed to Implement the second order (flushing with 15 ml between each medication). The afternoon nurse failed to administer 250 ml after the feeding and the morning nurse had used a portion of the 250 ml for dissolving the protein powder. The facility's RN was interviewed on June 10, 2008, beginning at approximately 12:55 PM. She stated that Client #3's POs had been written to reflect the what the nutritionist had recommended. The RN stated that she would seek clarification of the orders with the nutritionist. The nutritionist was in the facility the next day. At 9:53 AM, the RN said that she had just spoken with the nutritionist, who confirmed that they were indeed separate orders. Her expectation was that the client would receive a full 250 ml of free water at the very end of the food administration process. The 5-15 ml flushes inbetween each supplement and/or medication was in addition to the 250 ml after the meal. There was no evidence that the primary care physician and/or the supervisory nurses had monitored the G-tube feeding process to ensure accurate implementation of her POs, prior to the survey. W 331 483.460(c) NURSING SERVICES W 331 W 331 This Standard will be met The facility must provide clients with nursing services in accordance with their needs. as evidenced by:

This STANDARD is not mot as suideneed by

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
09G122			B. WING		06/12/2008		
NAME OF PE	ROVIDER OR SUPPLIER		3	EET ADDRESS, CITY, STATE, ZIP COD 020 STANTON ROAD, SE VASHINGTON, DC 20020	E		
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W 331	failed to ensure nur the needs of four of facility. (Clients #1 The findings include 1. Facility nurses from the potential sign a. Cross-refer to Wood to be coughing during he on June 9, 2008. It that this was not un coughed frequently two day program nuthat neither was aw during meals. Ever coughing should ha attention, day prograte to notify them. b. While being fed was again observed continued presentir coughed and did not A surveyor alerted of facility at the time be directly; the RN inter c. When asked the support staff person her meals indicated frequently. According protocol, staff were	and record review, the facility sing services in accordance with the eight clients residing in the #2, #4 and #5)	W 331	W331 -mealtime protoco -signs symptom -mealtime protoco -mealtime protoco -mealtime protoco -mealtime protoco reports a. Cross reference to W127. b. Cross reference to W127. c. It is desirable client to cough meals to clear air way. Only included so respiratory, st	response for the during the hows signs	n.agoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2008 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE IDI WASHINGTON DC 20020 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG OR LSC IDENTIFYING INFORMATION) TAG W 331 Continued From page 36 W 331 W331, continued. not, however, instruct staff on how to respond of breath, etc... if/when they observed coughing or other signs. The client's Health Management Care Plan (HMCP), staff are instructed to notify/about the number on duty who will provide the necessary interventions. dated May 6, 2008, directed staff to adhere to the feeding protocol and to monitor for signs of aspiration. The HMCP did not, however, elaborate on how staff should respond to coughing. d. On June 10, 2008, at 2:53 PM, interview with the facility's RN revealed that staff were expected to alert the nurse on duty (24/7) if Client #2 or any of her peers were coughing during a meal. Staff had not, however, informed the nurse the previous evening. She further indicated that she was unaware of any coughing during Client #2's meals in recent months at home or at the day program. Further review of the client's record and follow-up interviews with the RN and Qualified Mental Retardation Professional revealed no evidence of a verifiable monitoring and reporting system to ensure the client 's health and safety. (2) Nursing etass/omep/ Home monager will monitor dental care 2. The facility's nursing staff failed to ensure Client #2 received dental care/ oral hygiene after every meal and before bedtime in accordance with the to ensure that dental hygiene is provided in oudowa dentist's orders, as follows: On June 10, 2008, at 2:11 PM, review of Client #2's accordance to the dental records revealed that on February 13, 2008, the dentist increased the frequency of daily oral recommendations. care to "brush teeth after meals and before bedtime." Her Health Management Care Plan HMCP will be updated to include the recommendations (HMCP), updated May 6, 2008, indicated staff

should "assist with oral hygiene PRN." Review of staff documentation revealed that she typically had

her teeth brushed before and after breakfast and then again at approximately 8:00 PM, as she

prepared for bed. At approximately 2:22 PM,

and staff training will be

provided as needed.

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PRINTED: 07/07/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE IDI WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) W 331 Continued From page 37 W 331 interview with the QMRP revealed that Client #2 did not receive oral care after lunch while at the day program. The afternoon LPN stated that day programs would not normally provide tooth brushing unless there were a "special order." The QMRP and RN stated that they follow the dentist's recommendations. At 2:24 PM, a direct support staff person assigned to the evening shift confirmed that the client's teeth were brushed before and after breakfast and at approximately 8:00 PM. There was no evidence that nursing staff ensured that Client #2's teeth were brushed daily at the frequency recommended by the dentist. 3. Cross-refer W322.4 3. Cross-refer to W322.4. Facility nurses failed to seek clarification of Client #3's G-tube feeding orders. Afternoon and morning medication nurses were observed administering less water than was ordered by the PCP and nutritionist, to ensure adequate hydration. W 338 483.460(c)(3)(v) NURSING SERVICES W 338 W 339 Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This Standard will be met as evidenced by:

Surveyor: 17815

The findings include:

sample. (Clients #2 and #4)

This STANDARD is not met as evidenced by:

Based on record review and interview, facility nurses failed to refer clients to medical specialists and clinics timely, for two of the four clients in the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 1020 STANTON ROAD, SE VASHINGTON, DC: 20020	
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W 338	1. Facility nurses faurinalysis testing in follows: a. On June 10, 200 #2's Health Manage September 25, 2007 May 6, 2008), reveatract infections (UTIs when she developed urinalysis testing she antibiotics, to ensure effective. Review of revealed that she hautily beginning on Olab reports failed to urinalysis during the antibiotic treatment. 2008, at approximat that, as standard prahad additional urinal after the antibiotic treatment. RN reviewed the lab that the next docume on May 30, 2008, 7 urinalysis. b. Client #2's ongoin included having rout every 6 months. Uri 2007 indicated an in antibiotic treatment. February 14, 2008, i cancelled - patient unext documented att was on May 30, 300	illed to refer Client #2 for accordance with orders, as 8, at 2:52 PM, review of Client ment Care Plan (HMCP), dated (updated periodically, through led she had recurrent urinarys). The HMCP indicated that did a UTI, she was to have ortly after treatment with a that the treatment was (Client #2's medical chart do been treated with Cipro for a ctober 12, 2007. Review of her show evidence of a follow-up weeks that followed her When interviewed on June 11, ely 12:10 PM, the RN confirmed actice, the client should have ysis approximately 2 - 3 weeks eatment was completed. The records and acknowledged ented urinalysis was performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the previous and physician's orders (POs) ine urinalysis tests performed months after the failed and 7 months after the failed and 7 months after the last	W 338	b. RN will provide and training on follow-recommendations adherence to large the reviews to ensure complicity with the sures provide additional as needed, to ensure complient this standard.	ditional 7.18.08 up //interventions also schedules outine further nce urd A follow-up sure

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED				
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NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020					
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W 338	2. Facility nurses far anticonvulsant testing orders, as follows: On June 9, 2008, at mile of Tegretol oral is The medication nurses was prescribed to comorning, review of its seizure disorder. The orders to obtain ser months. On June 1 review of her lab represent of the seizure of her lab represent or the seizure of her lab represent or the seizure. 3. Facility nurses far emergency room (Ewithin the same day established seizure. On June 10, 2008, neurology records v. PM. She was seen 2008. The correspondicated that she hon April 14, 2008. On the corres	illed to refer Client #2 for seruming timely and in accordance with 5:37 PM, Client #2 received 20 colution (400 mg equivalent), se stated that the medication control seizures. The next her POs confirmed that she had he POs reflected ongoing labourn Tegretol levels every 3 1, 2008, beginning at 11:02 AM, corts revealed a 6-month gap in egretol levels, between August ary 14, 2008. Alled to send Client #2 to the R) after experiencing 3 seizures of in accordance with their protocol, as follows: Client #2's seizure and vere reviewed, beginning at 3:34 by the neurologist on May 1, anding consultation report form ad experienced three seizures on June 11, 2008, at 2:30 PM, a pates dated April 14, 2008 back seizures of 30 seconds I was 6.00 WNL notified cian> and the Director of e. " The April 14, 2008 Seizure so reflected 3 seizures on that eview of the agency's Protocol or revealed that if a client seizure in 24 hours, send client	W 3	2. RN WILL provide a training as need adherence to the schedule. Appropriate discussible of nurses who for adhere to the set forth. 3. RN WILL review texts eurnen. As needed. Gerzeires also chant #2 dipresent any sie distress and he were w/m nor	plinary population ul to guidelines and protocol erved by id not is the				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUIL	DING		COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3020 STANTON ROAD, SE WASHINGTON, DC 20020	E		
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W 338	client's records did ER on April 14 or 15 confirmed the seizu clients should be ta a third seizure in on seizure record, the had not been taken the protocol. 4. Facility nurses fa anticonvulsant testicorders, as follows: Cross-refer to W11 records, on January her PCP ordered "CLFT test." a. Lab records indicanticonvulsant level 2008, more than 6 v. b. Even though the said to test "all antic Keppra (one of the prescribed) were no nurses suggested the needed.] c. According to lab liver function tests pwhich was almost 4 2008 orders. It should be noted the neurologist on Mocumented "Depak	not, however, reflect a visit to the 5, 2008. At 2:50 PM, the RN re protocol was current and that ken to an ER if they experience the day. After examining the RN acknowledged that Client #2 to the ER in accordance with alled to refer Client #4 for seruming timely and in accordance with alled to refer Client #4's year 24, 2008, the neurologist and set all anticonvulsant levels and cated that Client #4's serum is were tested on March 11, weeks after they were ordered. January 24, 2008 lab orders convulsants," her serum levels of three anticonvulsants at tested. [Note: Interviews with the at Keppra levels were not reports, Client #4 had serum performed on May 19, 2008, months after the January 24, and when Client #4 returned to March 27, 2008, the neurologist of level is low 29.1 please rel and LFT." The neurologist	W 3	4. Cross reference w Al 322. b. Cross-reference c. Cross-reference to W 322.	338 and	andanci J.18-Of	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SU COMPLE		
		09G122	B. WIN	G	<u> </u>	1	06/12/2008		
NAME OF PR	OVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, 1 1020 STANTON ROA VASHINGTON, DC	D, SE	:		
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W 338	Continued From pag	je 41	W	338		2			
	liver function testing	This was, as noted above, 2008, or approximately 5	·		, 1	: *			
		iled to refer Client #4 for accordance with orders, as					N. 1. (200) 1. (200)		
	On June 12, 2008, at 10:20 AM, review of Client #4's medical chart revealed that on January 7, 2008, a urinalysis test had indicated bacterial infection. She was then prescribed Augmentin 500 mg twice daily for 10 days. Review of her lab reports failed to show evidence (to date) of a follow-up urinalysis in the 6 months that followed. At 11:47 AM, review of Client #4's HMCP, dated January 9, 2008 and incorporated in her January 11, 2008 ISP, revealed that she had recurrent urinary tract infections (UTIs). The HMCP indicated that after receiving treatment with antibiotics, she was to have follow-up urinalysis testing to ensure the treatment was effective. There was no evidence that facility nurses scheduled follow-up urinalysis in accordance with her HMCP.								
W 340	483.460(c)(5)(i) NUF	RSING SERVICES	w:	340	M340				
	other members of the appropriate protection measures that include	st include implementing with e interdisciplinary team, we and preventive health le, but are not limited to training eeded in appropriate health s.			Their Stan	dard wi ced by:	ll be met	n.19.08	
	Surveyor: 12301	and record review, the facility's document that all							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		09G122	B. WING		06/12/2008			
NAME OF PR	OVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 020 STANTON ROAD, SE VASHINGTON, DC 20020				
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W 340	measures (i.e. infect management), for or sample. (Client #3) The finding includes The review of unusurevealed that Client herpes infection at a 2007. Interview with that she provided infoot staff at the time of at 3:00 PM, further it was no documentation the training. 483.470(g)(2) SPAC The facility must furnand teach clients to a choices about the ushearing and other coand other devices id team as needed by the staff at the interved by the client and ensured that client and ensured that clients are sampled by the client and ensured that clients.	aining in preventive health ion control/ herpes he of the four clients in the all incidents on June 9, 2008 #3 received treatment for hospital on December 20, the home manager indicated ection control/ herpes training discharge. On June 10, 2008, herview revealed that there on available for review to verify E AND EQUIPMENT hish, maintain in good repair use and to make informed the of dentures, eyeglasses, emmunications aids, braces, entified by the interdisciplinary he client. In, interview and record review, insure devices and aids relisciplinary team (IDT) as were maintained in good repair ents received appropriate he eight clients residing in the #2, #3 and #5)	W 436	and conduct add training on in control/herpes. The Home Manager ha instructed to file	s been cill training m completion	s ondoned		

P.10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER ID I (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 436 Continued From page 43 1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client #1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 436 W 436 U 436 Continued From page 43 W 436 U 436 Continued From page 43 U 436 U 436 Continued From page 43 U 436 U 436	
NAME OF PROVIDER OR SUPPLIER ID I (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 436 Continued From page 43 1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client #1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 436 W 436 U 436 U 436 U 436 U 436 U 546 CONTINUED: CHEAT #1 WIll be schedule for further evaluation of molded shoes. QMEP will provide follower appropriate to be Sure.	
Summary statement of deficiencies PROVIDER'S PLAN OF CORRECTION PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 436 Continued From page 43 1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client #1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review Canada Continued Follow-unit provides follow-unit provides follow-unit program and in the home. On June 10, 2008, review Canada Continued Follow-unit provides	12/2008
W 436 Continued From page 43 1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client #1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review PREFIX TAG PREFIX TAG W 436 U 436 W 436 W 436 U 50, continued Cheut #1 will be schedule for further evaluation of molded shoes. Query will provide follow-u ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review	
1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client #1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review	(X5) COMPLETION DATE
29, 2008, revealed a recommendation for custorn- molded shoes due to "severely pronated ankles." On June 12, 2008, interview with the Qualified Mental Retardation Professional (QMRP) revealed that the team had agreed and an appointment for an evaluation (i.e. measurements, etc.) for custorn- molded shoes was scheduled for July 10, 2008. The QMRP presented a 719A form for the shoes, dated May 19, 2008. To date, the client remained without custorn-molded shoes. 2. The facility failed to ensure that Client #2 was offered liquids in a Wonderflo spout cup, as follows: Cross-refer to W127.3. On June 9, 2008, a direct support staff person was observed feeding Client #2 Boost Plus nutritional supplement (liquid) mixed with pureed foods at dinner. The mixture was thinner than the prescribed pudding consistency. She fed her the soupy mixture from a regular beverage glass, pouring it into her mouth from above, instead of using the Wonderflo spout cup as prescribed. When the RN intervened (after a surveyor alerted her to the client's coughing), the staff person said the Wonderflo cup was in the kitchen. Interviews with	7.10.08

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NAME OF PROMDER OR SUPPLIER 1D1 SUMMARY STATEMENT OF DEFICIENCES WASHINGTON, D. Q. 2020 WASHINGTON, D. 2020 WASHINGTON, D. Q. 2020 WASHINGTON, D. 2020 WASH	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
DAY 10 SUMMARY STATEMENT OF DEFICIENCIES PRETEX (EACH DEFICIENCY MIST BE PRECEDED BY PELL REGULATORY TAG) W 436 Continued From page 44 ther direct support staff the next day indicated that mixing Client #2's food with liquid supplement and feeding her in that manner had been a routine occurrence. 3. The facility failed to ensure that Client #2 received training and appropriate staff support in the use of a safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot outdoors. (Note: At the time, the air indoors felt comfortable to this surveyor.) Further interview with the day program staff revealed that the rafety harness should be secured at all times "for protection," to prevent her from leaning too far forward. On June 12, 2008, at 10:43 AM, the OMRP, RN and home manager all concurred that Client #2's safety harness should be secured at all times. They further indicated that the client was known to independently move her arm out from under the harness. The OMRP stated that she had reviewed this topic with residential staff at a recent (March 31, 2008) training. There was no evidence, however, that the facility had verified whether the harness was kept properly secured while the client was at day program. In addition, there was no evidence, however, that the facility had verified whether the harness was kept properly secured while the client was at day program. In addition, there was no evidence, however, that the facility had verified whether the harness was kept properly secured while the clients alleged habit of removing the safety harness had been addressed by her interdisciplinary team, to include a training program if indicated.			09G122	B. WING		06/12/2008			
PREFIX TAG GACH DEPICIENCY MIST BE PRECEDED BY FULL REQUIATORY TAG OR LSC IDENTIFYING INFORMATION) W 436 Continued From page 44 other direct support staff the next day indicated that mixing Client #2's food with liquid supplement and feeding her in that manner had been a routine occurrence. 3. The facility failed to ensure that Client #2 received training and appropriate staff support in the use of a safety harness, as follows: On June 9, 2008, beginning at approximately 11:01 AM, Client #2 was observed at her day program. Her right arm and shoulder were positioned outside of the safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot outdoors. [Note: At the time, the air indoors felt comfortable to this surveyor.] Further Interview with the day program staff revealed that her safety harness should be secured at all times. They further indicated that the client #2's safety harness should be secured at all times. They further indicated that the client was known to independently move her arm out from under the harness. at sleep stated that she had reviewed this topic with residential staff at a record (March 31, 2008) training. There was no evidence, however, that the clients was no evidence that the clients was no devidence however, that the client sheep had reviewed while the client was at day program. In addition, there was no evidence that the client saleged habit of removing the safety harness had been addressed by her interdisciplinary team, to include a training program if indicated.		OVIDER OR SUPPLIER		3	020 STANTON ROAD, SE	···			
other direct support staff the next day indicated that mixing Client #2's food with fluid supplement and feeding her in that manner had been a routine occurrence. 3. The facility failed to ensure that Client #2 received training and appropriate staff support in the use of a safety harness, as follows: On June 9, 2008, beginning at approximately 11:01 AM, Client #2 was observed at her day program. Her right arm and shoulder were positioned outside of the safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot outdoors. [Note: At the time, the air indoors felt comfortable to this surveyor.] Further interview with the day program staff revealed that her safety harness should be secured at all times "for protection," to prevent her from leaning too far forward. On June 12, 2008, at 10:43 AM, the QMRP, RN and home manager all concurred that Client #2's safety harness should be secured at all times. They further indicated that the client was known to independently move her arm out from under the harness. The QMRP stated that she had reviewed this topic with residential staff at a recent (March 31, 2008) training. There was no evidence, however, that the facility had verified whether the harness was kept properly secured while the client was at day program. In addition, there was no evidence that the client's alleged habit of removing the safety harness had been addressed by her interdisciplinary team, to include a training program if indicated.	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE CROSS- COMPLETION			
i i i i i i i i i i i i i i i i i i i	W 436	other direct support mixing Client #2's for feeding her in that moccurrence. 3. The facility failed received training and use of a safety harned on June 9, 2008, be AM, Client #2 was of the safety harness asked about the har surmised that she has because it was hot cair indoors felt comforther interview will revealed that her sa at all times "for prote leaning too far forward. AM, the QMRP, RN concurred that Client secured at all times client was known to out from under the had reviewed the recent (March 31, 20 evidence, however, whether the harness while the client was there was no eviden of removing the safe by her interdiscipling program if indicated.	staff the next day indicated that od with liquid supplement and nanner had been a routine to ensure that Client #2 dappropriate staff support in the ess, as follows: eginning at approximately 11:01 bserved at her day program. Houlder were positioned outside son her wheelchair. When ness, a direct support staff ad repositioned her arm butdoors. [Note: At the time, the portable to this surveyor.] the day program staff fety harness should be secured ection," to prevent her from ard. On June 12, 2008, at 10:43 and home manager all tr #2's safety harness should be. They further indicated that the independently move her arm arness. The QMRP stated that is topic with residential staff at a 2008) training. There was no that the facility had verified as was kept properly secured at day program. In addition, ce that the client's alleged habit ety harness had been addressed ary team, to include a training		3. Reference responsibility. QMEP WILL CONSULT Physical thempist further evaluation recommendation Client # 2'= Bafet Araining as need.	with the for and regarding harness. additional ed.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING								(X3) DATE SURVEY COMPLETED		
		09G122	B. WING								6/12/2008		
NAME OF PR	OVIDER OR SUPPLIER			3020	D STA	RESS, C NTON I GTON	ROA	D, SE	į	ję			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION ST TAG REFERENCED TO THE APPROPR					HOULD	BE CROSS-	COMPLETION DATE			
W 436	2008, at 3:10 PM, rebeen requisitioned fone was discarded time, there was no a Review of Client #3 revealed a recommendatives "to assist i breakdown." The IS indicated the mattre and that it should be 12, 2008, at 4:15 Pl a 719A form that was earlier. The home in had not yet been sufthe primary care phosphare of the primary care phosphare in the left front and reavinglier on June 9, 2008, at the left front and reavinglier on the edge the vinyl covering of armrest was missing PM revealed a large in the center of the foam was exposed, the seat of the client approximately nine that the client had again. At the time of	roup home manager on June 11, evealed a new air mattress had or Client #3 after her previous (due to a foul odor). At that air mattress on the client's bed. Is ISP, dated June 15, 2007, endation that she have an air in the prevention of skin ISP maintenance schedule is should be monitored daily explaced as needed. On June IM, the home manager presented its dated May 20, 2008, 3 weeks manager stated that the form bmitted as they were awaiting visician's signature. It to ensure that Client #5's intained in good repair, as int #5 seated in her wheelchair 5:38 PM, revealed the treads on air wheels were very worn. The ges of the foot box was torn and in the front end of the right gray. Further observation at 6:51 is hole (2 to 3 inches in diameter) molded seat from which the Staff interview indicated that it's chair was repaired months before the survey and amaged her own wheelchair of the survey, there was no had been implemented to	W 4		5)	amer addi on r and stat whe bire	eld her her cher ail	Home No constitutions of the c	laraging, in-e	repe ervice netwo nt in the an	ll provid Haining Than	e of	

PRINTED: 07/07/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE IDI WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG W 436 Continued From page 46 W 436 W436, continued ... was maintained in good repair. ampey Home Manager will W 474 483.480(b)(2)(iii) MEAL SERVICES W 474 continue to monitor the status of all adaptive Food must be served in a form consistent with the equipment and report on the status monthly. developmental level of the client. This STANDARD is not mot as avidenced by Surveyor: 17815 Based on observation, staff interviews and record W474 review, the facility failed to ensure each food was This Standard will be met provided in the prescribed texture, for one of the 1,23-08 four clients in the sample. (Client #2) as evidenced by: ongant The findings include: 1. Reterence response to 1. On June 9, 2008, at 11:31 AM, Client #2 was presented her lunch plate at the day program. She W120, W194 and W111. was served, among other food items, pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. 2. Reference response to W120, W194 & W111 2. Later that day, at 6:21 PM, residential staff was observed mixing Client #2's dinner foods (pureed chicken, green beans and mashed potatoes) together into one wide-rimmed beverage glass. After the client declined spoonfuls of the food mixture, the staff stirred some Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. At 6:38 PM, review of her mealtime protocol, dated October 12, 2007, revealed that she was to receive foods "pureed with added fiber, pudding consistency." This was consistent with her physician's orders, dated June 1, 2008 ("pureed to

pudding consistency"). Prior to the survey, the facility failed to ensure that foods served in the home and at day program were of the texture

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G122 06/12/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE 1 D I WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG (X5) COMPLETION DATE PREFIX TAG W 474 Continued From page 47 W 474 prescribed by Client #2's physician.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		HFD03-0001		B. WING		06/	12/2008			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE	: :	1.			
IĎI		·		TON ROAD						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORREC		CORRECTION SHOULD BE CROSS- PRIATE DEFICIENCY)	(X6) COMPLETE DATE		
1 000	INITIAL COMMEN	TS		1 000						
1 002	2008 through June four residents was population of eight disabilities. In add conducted of a fifth The findings of this observations, interand another reside interviews with staf programs, as well a	was conducted from Jo 12, 2008. A random s selected from a resident women with various de ition, a focused review resident's mealtime properties with one resident views with one resident nt's court-appointed gut if in the home and at two as the review of clinical rds, including incident	eample of int was rotocol. it's sister pardian, o day I and	1 002	IAD 3					
1 002	Each GHMRP licer demonstrate that h provisions of D.C. I Chapter 19 govern	PROVISIONS usee and residence directly a considered and residence directly and a considered and residence directly and a considered and residence and residence and residence and addition to this chapter a considered and a considered and a considered and residence and	hat the Title 6, mentally	1002	3500.2					
	Surveyor: 17815 Based on observat review, the GHMRI failed to demonstra the provisions of Ti Code (formerly call Title 6, Chapter 19 mentally retarded p		ce director rstood that D.C. C. Code, ights of		This Statu endenced		be muet as			
lealth Regula	residents' rights to	receive an updated Inc			. "					
_	Yha	MUA BAUNCA Risupplier representativi	E'S SIGNATURE			r.s		7/17/08		

FLC011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPI	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
-		HFD03-0001		B. WING		<u>:</u> :	06/1	2/2008	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE				
101				TON ROAD, TON, DC 200					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRE		DRRECTION (OULD BE CROSS- NATE DEFICIENCY)	(X5) COMPLETE DATE	
l 002	Support Plan (ISP)	ge 1 vithin 30 days after ac § 7-1305.04(a), forme		I 002	1	:			
	1964], as follows: Resident #1 was ad January 31, 2008. T	mitted to the GHMRP he resident's interdisc new ISP on May 23,	on Siplinary		;				
	2. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows:				2.	# # # # # # # # # # # # # # # # # # #	1		
	a. Cross-refer to I422.1. Resident #1 was admitted on January 31, 2008 with a Behavior Support Plan (BSP) as part of her Individual Support Plan (ISP), that was developed by her former provider. There was no evidence that staff implemented Resident #1's BSP.				a. Cross				
	ensure that Residen	22.2. The facility faile t #1 had custom-molo interdisciplinary tean	led shoes		b. Cross-re	Ē 1			
	ensure that Residen	2.3. The facility failed t #2 received training oport in the use of a sa	and		e. Cross-n	<i>i</i> .		,	
	d. Cross-refer to I422.4. The facility failed to ensure that Resident #3 had an air mattress as prescribed by her interdisciplinary team.				d. Cross-v	1	!		
	e. Cross-refer to I422.5. The facility failed to ensure that Resident #5's wheelchair was maintained in good repair.				e. Closs-1	refer to	1422.5		
lealth Poorts		to demonstrate prote	ction of		3. 				
icalin Kegula	tion Administration						ļ		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/OIDENTIFICATION NUMB		A. BUILDIN		(X3) DATE SURVEY COMPLETED					
		HFD03-0001		B. WING 06/12/2008							
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE							
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I 002	residents' rights to rebalanced, varied and ordered by a physic specialized diet [Titt formerly § 6-1965(f)] a, Cross-refer to 156 implement Resident protocol as written. b. Cross-refer to 146 provide water to Resamounts prescribed 4. The facility failed residents' rights to remedical attention [This 1305.05(g), formerly a. Cross-refer to 146 to the emergency reseizures within the significant of the commended followand post-treatment of the commended followand post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-refer to 146 referred timely for many post-treatment of the cross-referred timely for many post-treatment of	eceive a nourishing, we discount appetizing diet, and ian and/or nutritionist, e 7, Chapter 13, § 7-1], as follows: 20.2. GHMRP staff far #2's diet orders and in the primary care put to demonstrate protective prompt and additle 7, Chapter 13, § 7 or § 6-1965(g)], as follows: 20.7. Resident #2 was a market experiencing same day, as indicated.	where to a 305.05(f), siled to mealtime siled to be in the physician. So to sent a 3 d by the sent d/or agement cons.	1002	Cross refer to 1500.7 b. Caoss-refer to 1401 4. Reserve responded 1305.05 (g). a. Cross-refer to b. Cross-refer to b. Cross-refer to b. d. Cross-refer to b. d. Cross-refer to b.	.4 to 17 1401.7 401.2/6	7.13.08 ongern				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTII A. BUILDING		NSTRUCTI	ION			- ;	(X3) DATE SURVEY COMPLETED		
		HFD03-0001		B. WING	· - ·					<u>}</u>		06/1	2/2008
NAME OF PE	OVIDER OR SUPPLIER		STREET ADDRE		•	CODE							
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1 002	Continued From pag	ge 3		1 002		,			, ,	į į			
;	5. The facility failed residents' rights to n all incidents (examp investigate an injury Chapter 13, § 7-130 as follows:	ediately of roughly tle 7,		5, (Lioss	ref	er :	+ o	1305.	.10			
	Interview with Qualif Professional (QMRP 4:10 PM, revealed the the facility on Janua and her current Beh incorporated the use awake hours, specif was verified as being updated Individual S 23, 2008.	eginning at hitted to previous BSPs) ng during PM. This her						:					
	On June 9, 2008, and that on May 1, 2008 Client #1 was heard her bedroom. Staff her seated on the floknee, and a swollen emergency room revincident report did no sustained the injurie QMRP acknowledge at the time of her injurient.	O AM, ations" in and found o her right on at the orain. The ent iew, the											
	investigation report, that even though Cli on-one supervision,	review of the corresp dated May 5, 2008, re ent #1's plan prescrib beginning at 6:00 AM ailed to address this i	evealed ed one- , the						:				
		to demonstrate prote ave their personal rec			6.				:				
lealth Recula	tion Administration	 		1		1	- ,		,	1	·····		
STATE FORM			6546	۱ ا	LC01	1	:				I.	continua	tion sheet 4 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		HFD03-0001		B. WING _	·		06/1	2/2008
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
1D1				TON ROAD		;		
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1 002	Continued From pag	je 4		1 002		· · · · · · · · · · · · · · · · · · ·		
	a. Cross-refer to I29	- 92.1/.2/.3 The GHMR	P nursing		a. Cross - ie	Jer 1292	.V2/3,	7.23.03
	staff failed to update and keep current the Health Management Care Plans of Residents #1, #2 and #5.				h. Clare - r	elene to	1292,4/5/6	
	b. Cross-refer to I292.4/.5/.6 The GHMRP failed to ensure that Resident #4's record included a summary of each significant contact by a professional person with a customer (i.e. neurological records and alleged telephone conversations with primary care physician and other professionals).							
·	7. The facility failed as follows:	to ensure Resident#	1's safety,		7. Reference Federal	e respon	ise to nay report	7,23.03
	the QMRP revealed to the facility on Januwas known that Resisupervision and had However, review of ishe had experienced January 31, 2008 - Mad one-on-one staff PM, there were 3 injusted End of injuries was addition, the resident severely pronated fe physical therapist reshoes. She had not orthopedic specialist specialized shoes mis was no evidence that	. A June 9, 2008 inter that Resident #1 was uary 31, 2008. At that ident #1 required closs a history of injuries denoted incident reports reveald numerous falls betway 1, 2008. Even the fassigned between 6 uries documented sine was updated in Material of unknown originated an impaired gait et. On February 29, 200 commended customy yet been evaluated by and remained without the facility implements ansure the resident's second to the facility implements and the resident's second that the facility implements are the f	admitted t time, it e ue to falls. led that een ough she AM - 10 ce her irch 2008. In due to 2008, the nolded y the t the er. There		W436.			
ealth Regulat	tion Administration	 						,

P.20

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 06/12/2008	
NAME OF PR	ROVIDER OR SUPPLIER	111 505-0001	STREET ADDR 3020 STAN WASHINGT	TON ROAD				2/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGI DENTIFYING INFORMATION)	1	ID PREFIX TAG	,		D BE CROSS-	(X5) COMPLETE DATE
1 047	Each GHMRP sha meals, which are s are suited to the d	RVICE / DINING AREAS Ill be responsible for ens served away from the Ghietary needs of residents dividual Habilitation Plan	uring that HMRP, as	í 047	1047 3502.5			
	Surveyor: 17815 Based on observa review, the facility provided at the day	t met as evidenced by: tion, staff interviews and failed to ensure that food y program in the prescrib the four residents in the	d was bed		This Stati	ite will b	e med	7.22.08
	AM, Resident #2 withe day program. food items, pureed burger and gravy with consistency. Inter Qualified Mental R as review of staff the vidence that the following the staff that the lanch meals at the	es: 2.2. On June 9, 2008, at was presented her lunch She was served, among I beef burger with gravy. Was of a thin and watery views with the GHMRP fetardation Professional, raining records, failed to GHMRP continuously more day program, to ensure meals in accordance wi	plate at other The RN and as well show onitored that		Cross-ref	er to 15	500.2	
I 055	Each GHMRP sha proper feeding tec appropriate use to	RVICE / DINING AREAS Il train the staff in the us hniques and monitor the assist residents who rec ocedures or utensils.	e of ir	1 055	1055 3502.13			
lealth Regula	ation Administration						·	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD03-0001		B. WING		06/12/2008
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, ST.	ATE, ZIP CODE	-
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES 'BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS- COMPLETE
I 055	Surveyor: 17815 Based on observation verification, staff failled in implementing resistance of the eight residents #2, #3 and Cross-refer to I229. staff displayed comporders for Residents 3504.1 HOUSEKEE	on, interview and record to demonstrate cordents' feeding protocoldents residing in the and #5) The facility falled to extency in implementing #2, #3 and #5.	mpetency ols, for facility. ensure ng the diet	1 055	This Statule will be as evidenced by: Cross-refer to 1229	
	maintained in a safe sanitary manner and dirt, rubbish, and object of the sanitary manner and dirt, rubbish, and object of the sanitary manner and object of the sanitary maintain the clean, orderly, and at the findings include on June 11, 2008, of environment beginning following: 1. One trash can have trash can lids were the available.	net as evidenced by: on and interview, the Ce interior of the facility ittractive manner. : observation of the the ng at 2:40 PM reveale d a large tear on the s orn and one can lid w	ed the ide. Two as not		This Statute will be evidenced by: 1. The trash can has replaced.	been 6-20-08 ongoing
lealth Regula	2. The upholstery on the arms of the love seat and the two arm chairs located in the foyer were very worn lation Administration			·	z. Upholstery will be replaced as needed	1.

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	ICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
-, , ,		HFD03-0001		B. WING		06/1	2/2008	
NAME OF PR	OVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE STANTON ROAD, SE				
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TAYEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE- DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETE DATE	
	descriptions with e employment and a This Statute is not Surveyor: 17815 Based on review o made available, the having discussed t with every employee employment and a The findings included On June 11, 2008, personnel records 1. no evidence of phire (or otherwise) (S5 and S6); and, 2. there was no evidence of the control of the contr	nall discuss the content ach employee at the beta tleast annually thereaf met as evidenced by: f personnel records that a GHMRP failed to doo the contents of job describe at the beginning of tleast annually thereaf are: beginning at 8:47 AM, revealed: iob description reviews for 2 of the 13 direct suit of the other 11 direct suit of	eginning ter. at were ument criptions ter. review of at time of upport staff ws of job upport staff by report annually rtification and and that	1 203	1. Job descriptions This statute will be eviden 1. Job descriptions completed at the hire and annual thereafter, Home Manager will that all documents filed and available review. 1206 3509.6.	are of the consume	C-10.08	
lealth Regula	tion Administration	-						

P.23

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/OIDENTIFICATION NUMB		(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD03-0001		B. WING		06/12/2008
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE	
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· I 206	Continued From page	ge 8		I 206	1206	
	This Statute is not met as evidenced by: Surveyor: 17815 Based on Interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include:				This statute will as evidenced by.	be met
*	Review of the perso beginning at 8:47 Al	nnel records on June M, revealed the follow cates/ inventories on t	ing;		1. Human Resource WIN continue to 1 and track health o	monitor 6.13.08 Lertificates
	made available for r	ealth certificates/ invel eview for 2 of the 13 o d S6) as well as 2 of the	lirect		Human Resource will continue to se required notices to expiration of	na prior date.
	LPN (N1) had expire	ciency. See deficienc			Health Certicales Identified Staff File at the time review.	NOW INC. OF L
I 223	3510.4 STAFF TRA			I 223	1223	
	participation shall be	m agenda and record maintained in the Gh by regulatory agencie	IMRP and		This Statute will as evidenced by:	be met
	This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record verification, the GHMRP failed to maintain the agenda and signature sheet of attendees for every staff in- service training session.					
STATE FORM			8	899	EL C011	If continuation sheet A of 30

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIR	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD03-0001		B. WING	1	06/12/2008
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST.		
IDI				ITON ROAD ION, DC 20		
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1 223	Continued From page 9			l 223	1223	
	The finding includes: Resident #1 was admitted to the facility on January 31, 2008. Her records indicated an ongoing history					
					Reference response federal deficiency re W149, W153 and W	to
	humerus." Interview	atus post fracture of t wwith Qualified Menta	1		WING WISS and W	2001 154.
	at 4:10 PM, revealed	sional (QMRP) on Jun d that the resident's p lan (BSP) developed t	revious			
	former provider had	incorporated the use MRP said she had re	of one-on-			
•	admission. Howeve	isting BSP at the time er, review of staff in-se	rvice			
	10:00 AM revealed	June 11, 2008, beginr no evidence that an a ttendees had been us	genda and			
	document the training	ng. A request was ma nal information was pr	ide:		;	
	revealed that Reside	nat review of incident ent #1 had experience ry 31, 2008 - May 1, 2	ed four			
					1226	
1 226	3510.5(c) STAFF TI	RAINING		1 226	3510.5 (C)	
;	This Statute is not a Surveyor: 17815	met as evidenced hu			This Statute will be as evidenced by	e met
,	Based on interview and record review, the facility's nursing staff failed to document that all staff had					
	received training in preventive health measures (i.e. infection control/ herpes management), for one of the four residents in the sample. (Resident #3)				0-10	
					Reference response to federal definency ref	W
	The finding includes	3 ;	:		imeral devicement let	ΣΠ΄.
	The review of unusu	ual incidents on June	9, 2008			
Tealth Regula	ation Administration		 			

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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		HFD03-0001		B. WING		06/12/2008	
NAME OF PR	ROVIDER OR SUPPLIER		3020 STAI	RESS, CITY, STA NTON ROAD TON, DC 20	, SE		
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I 226	revealed that Reside herpes infection at a 2007. Interview with that she provided in to staff at the time o at 3:00 PM, further i	ge 10 ent #3 received treatm i hospital on Decembe in the home manager in fection control/ herpes f discharge. On June nterview revealed that on available for reviev	er 20, ndicated s training 10, 2008, t there	1 226			
l 227		ım shall include, but n	ot be	I 227	1227 3510.5		
	This Statute is not a Surveyor: 17815 Based on interview a made available, the staff had received coresuscitation (CPR), policies.	for staff and residents Pet as evidenced by and review of personn GHMRP failed to ensertification in cardiopu in accordance with a	nel records ure that all Imonary		This Statute will be evidenced by:	e met as	
	personnel files and s revealed the following 1. The CPR certifications support staff (S3) has	eginning at 8:47 AM, staff in-service training	records rect		All staff will be to attend the ne scheduled CFR/t Training Manager	will .	
	(N1) had expired in I	cumented evidence of			continue to monitary track complians take appropriate as needed to ensu all assumed staff	e and e and octions re that	
Health Regula	tion Administration	·····)Age	-LC011	If continuation sheet 11 of 39	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				A. BUILDIN	PLE CONSTRUCTION		COMPLE	
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1 227		ge 11 direct support staff (S	6), and	I 227	1227, continu Current CPR	ued . certific	ations,	
,	b. 2 of the 3 LPNs (N2 and N3) employed	l .			i		
l 22 9	3510.5(f) STAFF TR	AINING		I 229	1229 3510,56	•		
-	Each training progra limited to, the follow	im shall include, but n ing:	ot be			: 1 :		
į	residents to be serve behavior manageme	elated to the GHMRP ed including, but not li ent, sexuality, nutrition imunications, and ass	mited to,		This Statul evidenced	e will be by:	. met as	
	Surveyor: 17815 Based on observation verification, the GHM demonstrated compresidents' feeding presidents.	met as evidenced by: on, interview and reco MRP failed to ensure t etency in implementin rotocols, for three of th the facility. (Residen	hat staff g ne eight		1		1	
	The findings include	:			1. Reference federal de	response	to	7.10.08
		to ensure staff display ementing Resident #2			I	fliciency v and W14		
Health Beauti	eating lunch at her of AM. Her meal include gravy that was of a to PM, review of her model, 2007, revealed to a "pudding consist with her physician's	Resident #2 was obstay program, beginnin ded pureed beef burgehin and watery texture ealtime protocol, date hat her foods should betency." This was conorders, dated June 1, ack of the mealtime program	g at 11:31 er with e. At 1:34 d October be pureed sistent 2008.					
Health Regula STATE FORM				6899	FLC011		tf continua	dion sheet 12 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	: : : : :	(X3) DATE SU COMPLET		
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I 229	Continued From page 12			I 22 9		. ,	1	
	staff had received training 6 months earlier, on November 29, 2007.					2	: : :	
	presented her dinne observed mixing her green beans and matches one wide-rimmed be resident declined sp staff stirred some Variature, rendering it As previously noted, pudding consistency. Because Resident # during the end of he by this surveyor that at a rapid pace, she that her food had no The RN pulled staff with them. She then Qualified Mental Ref	at 6:21 PM, Resident, Residential staff was dinner foods (pureed ashed potatoes) together age glass. After the confuls of the food mismilla Boost Plus into the consistency of a the food was to be property. 2 was observed to conful to the RN was in her food had been property to been of pudding confusive and reviewed the shared the informatic tardation Professional did retrain all of their staffic and the staffic to the sta	as chicken, her into he xture, the hick soupureed to a ugh nformed esented dly and esistency, he protocol on with the who		ì			
	On June 10, 2008, at approximately 5:00 PM (before the dinner meal), the RN and the LPN on duty provided a more indepth in-service training for all of the staff regarding the danger posed to health and safety if/when a resident aspirates food or beverage and therefore, the importance of adhering to the residents' mealtime protocols. On June 11, 2008, staff in-service training records were reviewed, beginning at 10:00 AM. The most recent training on residents' mealtime protocols, prior to this survey, had been documented on March 21, 2008. Even though there had been some training provided, the observations and staff interviews indicated that the March 21, 2008 training had been ineffective.				:			
laalik Darid	tion Administration		[<u> </u>		!	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	:	(X3) DATE SU COMPLE	
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1 229	Continued From pag	ge 13		1 229			:	
		to ensure that nursing cy in implementing Rollows:			:	÷ .		
	June 10, 2008. At a medication nurse place up to Resident #5 at a pronounced tongular Medication Adm June 2008 revealed thickened to a nectal 2008, further review Speech/ Language & 2008, and a Nutrition	ation pass was observed pproximately 7:54 AM acced a cup of unthicked she drank. The reset thrust. At 9:40 AM, inistration Record (Mashe was to receive allor consistency. On Jurof her record reveale Assessment, dated Mashessessment, dated Mashessessment, dated	1, the ened water sident had review of AR) for I fluids ne 12, d a arch 12, February					
и	receive "pureed food because she "canno	ch indicated that she want and nectar-thick lique to tolerate thin liquids when to her tongue thruits.	ids" or foods of		·	*	: : : : : : : : : : : : : : : : : : : :	
	that nursing staff had implementation of R orders. On two occa-	322.4. There was no d received training on esident #3's G-tube feasions, different nurse resident less water thop and nutritionist.	proper eeding es were		3. Cross re to W3:	Serence 22.4	response	7.23.08
		·				a :	:	
1 292	3514.3 RESIDENT I	RECORDS		1 292	1292		:]
		clude, but not be limite . Law 2-137, D.C. Cool.).			3514.3 This State	te will	be met as	
	Surveyor: 17815	net as evidenced by: and record review, the	GHMRP		enictes ices	~ ~~~~	· · · · · · · · · · · · · · · · · · ·	;
lealth Regula TATE FORM	tion Administration	Saon regords III	486	6 9	FLC011	-	If continuat	on sheet 14 of 39

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/		(X2) MULTI	PLE CONSTRUCTION	•	(X3) DATE SI	
				A. BUILDIN B. WING	G		1	
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I D.I		· · · · · · · · · · · · · · · · · · ·		NTON ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S P (EACH CORRECTIVE REFERENCED TO THE		BE CROSS-	(X5) COMPLETE DATE
1 292	(now Title 7, Chapter residents in the san The findings included Title 7, Chapter 13; 6-1972) Complete records formaintained and shap professional person are directly involved (9) "A summary of professional person Resident #4 experied January 14, 2008 whospital. On June 19 January 14, 2008 whospital. The facility's number of the facility's number of the facility's number of the facility is numbered that Resident #1's Healt (HMCP) to reflect the Review of unusual in revealed that Resident admission to the 2008. The HMCP, of documented osteopareas of concern. Twould be free from 19 January 14, however, reflecting the first professional person that the facility is numbered to the professional person that the facility is numbered to the facility i	quirements of D.C. Laver 13), for one of the forple. (Resident #4) e: D.C. Code 7-1305.12 or each customer shall be readily available as and to the staff work in These records shall each significant contains with a customer enced multiple seizure with led to her admissivere reviewed, beginned reports and document to with medical profiner record, as follows: sing staff failed to update the medical profiner record, as follows: sing staff failed to update the medical profiner record, as follows: sing staff failed to update the medical profiner record, as follows: sing staff failed to update the medical profiner record, as follows: sing staff failed to update the medical profiner record, as follows: the group home on Januupdated May 23, 2008 orosis and a history of the goal was that the refalls/injuries. The HMC to the physical therapis recommendation that second	(formerly I be to ters who II include: ct by a s on ion to a sing at 9:15 intation of fessionals ate Plan es. 008 falls since ary 31, ffall as resident CP did t's	1292	Reference her federal defice W1322 and	sporree t enay rep w338.	ort	7.23.08
lealth Recula	tion Administration				1	:	· ···· _·	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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1 292	Continued From part 2. The facility's nur. #2's HMCP to reflect On June 11, 2008, a review of Resident arevealed that on Fe had discovered a "oright toe. The podia until healed. On Fe that the "fifth toe right foot, in the resident for the next wrote "There is tissificated, nurse made at fifth toe right foot" resident's HMCP, us how evidence that what now appeared concern. 3. The facility's nur. Resident #5's HMC and beverage textur. Resident #5's HMC and beverage textur. Resident #5 had a June 10, 2008, at a medication nurse p. She had difficulty dittled to the side, ar "Nectar-thickened I mealtime protocol, Speech/ Language Resident #5's HMC physician's orders forder. There was a concern. 4. There was a concern that was a concern that sought to clarif.		ent orders. PM, potes podiatrist her fifth conitoring rse wrote healing diatrist odiatrist of the failed to ressed alth sure ect food ders. rust. On I, the up of water. ler head bib. on her on and ver, , 2008 and reflect the y nurses a survey. ing that on	1292	Reference 18 WIZO, WIII WISZ WISY W338, WI	sponse to, will., w322	7.2308	
-lealth Regul	ation Administration				i .			

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

3020 STANTON ROAD, SE WASHINGTON, DC 20020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS- EFFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
(X4):ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1*292 Continued From page 16 There was no note attached, however, and further review of her medical records failed to show evidence of the neurologist's report. 5. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on	PROVIDER'S PLAN OF CORRECTION (X6) EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1°292 Continued From page 16 There was no note attached, however, and further review of her medical records failed to show evidence of the neurologist's report. 5. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on	EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPLETE
There was no note attached, however, and further review of her medical records failed to show evidence of the neurologist's report. 5. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on	
review of her medical records failed to show evidence of the neurologist's report. 5. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on	
AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on	
"report to follow." There was no EEG report attached to the consultation form, however, and further review of her medical records failed to show evidence of the EEG report.	
6. Resident #4's records indicated that on January 24, 2008, the neurologist ordered testing the serum levels of her anticonvulsant medications. She was prescribed Tegretol, Depakote and Keppra. A telephone order dated January 24, 2008 indicated that her primary care physician (PCP) concurred; he ordered "Get all anticonvulsant levels and LFT test." Lab reports indicated that the resident's Tegretol and Depakote were tested; however, her serum Keppra levels had not been tested since October 3, 2007. On June 12, 2008, at approximately 12:15 PM, the RN stated that the	
Director of Nursing, the pharmacist and eventually the neurologist and PCP had all stated that Keppra levels were not needed. After examining the resident's chart, however, the RN acknowledged that conversations with those professionals, reportedly clarifying the lab order, had not been documented appropriately in Resident #4's record. At the exit conference later that afternoon, the DON corroborated what the RN had stated. She did not, however, present documentation of contacts with the neurologist and/or PCP regarding clarifying the order.	
ealth Regulation Administration 'ATE FORM 5800 51 CO14	•

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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I 379	Continued From pag	ge 17		I 379				
I 3 79	79 3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5,			I 379	1379 3519,10	>		
	Health Facilities Div incident or event wh a resident 's health well being or in any risk. Such notification immediately and sha	notify the Department ision of any other unusich substantially inter, welfare, living arrang other way places the on shall be made by teall be followed up by venty-four (24) hours of	sual feres with jement, resident at elephone vritten	•				
	Surveyor: 17815 Based on interview staff failed to consis	met as evidenced by and record verification tently report significan if Health within the rec	nt incidents		enidence			
	The finding includes:				Reference	e respon deficienc	se to y report	7,72,08
	the primary care physend Resident #1 to corresponding invessing was seen at the morning (May 1, 200 incident report, how report was prepared day (May 2, 2008). the Department of H	dent report dated May ysician instructed the pain an emergency room stigation report indicate ER at 9:30 AM on the 108). Further review of ever, revealed that the dat 2:00 PM on the for According to the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the incidently was notified via an 24 hours later, at 2:00 PM on the 2:00 PM	nurse to The ed that e same f the e written llowing dent report, fax		141154, WI	53, W327	T. W318	ongains
	Health Regulation A	of the Department of Idministration incident In had been no immedi	records			· 		
lealth Regula	ation Administration			68 90	FLC011	:	If continua	tion sheet 18 of 39

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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1 379	Continued From page	age 18		1 379	1		
		ion. The first documen é fax received more tha ident occurred.		,			
I 4 01	3520.3 PROFESS PROVISIONS	ION SERVICES: GENE	ERAL	I 401			
	and evaluation, ind developmental levi services, and servi	ces shall include both deluding identification of els and needs, treatme ices designed to prever ther loss of function by	nt				
	Surveyor: 17815 Based on observary review, the facility general medical car	t met as evidenced by: tion, staff interview and failed to provide prever are for three of the four esidents #2, #3 and #4)	itive and residents		This Statute will as evidenced by: Reference response	be met	
	The findings include	le:					
	ongoing seizure ac referrals to hospital observation and as resident was taken 2008 after experient that evening. The reviewed, beginning She was prescribe medications; Tegre Depakote was add	indicated that Residentivity, some of which lead emergency rooms for esessment. For example to a hospital ER on Jancing 3 back-to-back seresident's medical record on June 11, 2008 at 1d the following anticonvetol, Keppra and Depaked to her regimen on Ang deficient practices we	d to further le, the nuary 14, eizures rds were 5:08 PM. rulsant ote; the ugust 8,		Appropriate medical was provided for a #2,#3, and #4, It cattle status of #4 was stable and adverse side effect following the service activity.	chent I no Is med une	7.22.08 ongoinu
	The facility failed to refer Resident #4 for serum anticonvulsant testing timely and in				Protocol will be revi and revised as nee	ened ded.	
ealth Regula TATE FORM	tion Administration		1	8892	FLC011	If continuation	on sheet 19 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPI	(X3) DATE SURVEY COMPLETED				
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l 401	Continued From pa	ge 19		1401		- 1		
	example, on Janua increased her daily requested updated January 24, 2008, concurred and order Her Tegretol and Duntil 6 weeks later labs performed on 2008 revealed contlevels. On March 2 requested updated Depakote was test weeks after the ord PCP also ordered I	hysician's orders (POs) ry 24, 2008 the neurole dosage of Depakote a anticonvulsant levels, the primary care physiciand labs for anticonvulsepakote levels were neurole (March 11, 2008). Resident 11, 2008 and Minued sub-therapeutic 17, 2008, the neurological labs. Resident #4's seed on May 19, 2008, moder. [Note: The neurole iver function tests on Jay 19, 2008.]	ogist and Also on cian (PCP) isants. ot tested sults of arch 26, Depakote st erum iore than 7 ogist and anuary 24,					
	b. The facility did not ensure that Resident #4 was seen by the neurologist at the recommended frequency. On January 24, 2008, the neurologist prescribed an increase in her Depakote. She was to have labs drawn and return to the clinic on March 4, 2008. The labs were not scheduled timely and she did not return for the March 4, 2008 appointment. She did return on March 27, 2008, at which time the neurologist noted that her labs reflected continued sub-therapeutic Depakote levels. The neurologist increased her daily Depakote dosage again. [Note: Her seizure records indicated 8 seizures in January 2008, 5 seizures in February 2008 and 3 more seizures in March 2008.]							
		292. The facility failed and sincluded the results test results.			c. Cross-1	relev to	1292.	
	d. The facility faile	d to implement an effe	ctive		4	: :		
Health Regula	stion Administration		26	969 =	LC011		lf continu	ation sheet 20 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X3) DATE SI COMPLE		
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l 401	At 5:08 PM, review of indicated that Reside selzures in October November 2007. Ho Seizure Observation had experienced 3 saddition, the neurolo October 30, 2007 cowell, no seizures" PCP and neurologis accurately reflected occurring. 2. The facility also faserum anticonvulsar accordance with PO lab orders to obtain months. On June 17 review of lab reports testing, between Aut 2008. Her seizure reto an emergency roda seizure. She expensive November 2007 as via Seizure for the medical team has implementation of her health and safety. Cross-refer to 1500.2 protocol, dated Octo POs, prescribed food	ummarize the extent of a Seizure Summary ent #4 had experience 2007 and 1 seizure in owever, review of indicated seizures each month. It is seizures each month ensultation form: " is There was no evident the number of seizure ailed to refer Resident the number of seizure serum Tegretol levels 1, 2008, beginning at revealed a 6-month of gust 16, 2007 and Felecords indicated she was no evident the number of seizure serum Tegretol levels 1, 2008, beginning at revealed a 6-month of gust 16, 2007 and Felecords indicated she was no evident #2 was at risk of effectively monitore are mealtime protocol, by the serum of the seru	charted 2 vidual ed that she In Ing on an Ing on Ing on an Ing on	I 401	2. Cross-defici		deval W322.	7.18.08 Ongo: 659
lealth Regula TATE FORM			68	3 9 9	FLC011	1	if continual	tion sheet 21 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COMPLETED				
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NAME OF PR	OVIDER OR SUPPLIER		3020 STAN	DDRESS, CITY, STATE, ZIP CODE ANTON ROAD, SE IGTON, DC 20020						
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∮ 401	were observed fe pudding consister coughing during hat home. Staff in not unusual for he however, in both unaware of her coprotocol revealed follow if/when the 4. The medical te #3 received hydrocare physician, as On June 9, 2008, medication nurse administered the with 10 ml water, Isosource HN. H flushing the G-tut Resident #3's tub fe following more 8:06 AM. The nucarbonate into wanuse then stirred water and administered a hat he process, inclusing plement and of 250 ml of water minimum, and the restriction.	e day program and in the eding her foods that we need. Resident #2 was one meals at the day proboth locations reported or to cough. Nursing stated they we oughing. Review of the no clear instructions for y observed her coughing earn failed to ensure that ition as ordered by the particular that it is not the particular that it is not the particular that it is not the particular that is not the particular that it is not the particular that is not that the particular that is not that the particular that is not the particular that the particular tha	re not of a bserved gram and that it was aff, are mealtime r staff to g. It Resident crimary PM, the g Resident cium e G-tube of s by water. It again on ginning at ium The powder into then roughout d after each ised a total io ml was a on a fluid	1401	RN will provide training and action as no conduct file an original ba	andits c				

, P.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
<u> </u>		HFD03-0001		B. WING		06/1	2/2008		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE				
: ID				ITON ROAD, ION, DC 200					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE ACT REFERENCED TO THE API	ION SHOULD BE CROSS-	(X5) COMPLETE DATE		
1401	Continued From paramedication pass ar June 2008 POs ref feeding orders, as "Free water flushes each feeding" "Flush tube with 15 medication and 5 medication every s "2 scoops Beneprotube" Both nurses had be 250 ml, which they throughout the feed to implement the sebetween each medicalled to administer morning nurse had dissolving the protestat Resident #3's if the what the nutrition RN stated that she orders with the nutrition RN stated that she orders with the nutrition RN stated that they her expectation was a full 250 ml of free food administration in-between each suin addition to the 250 ml of the state of the	age 22 and tube-feeding process. lected three separate an follows: s with 250 ml 4 times daised and water before and after an in three times daily via tein three times daily via administered at various ding process. Both nurse acond order (flushing with ication). The afternoon 250 ml after the feeding used a portion of the 25	ily after ily after ier each a G- uring times es failed th 15 ml nurse g and the io ml for io 2008, estated reflect The of the was in N said et, who orders, d receive f the lushes ation was	1401					
		e supervisory nurses had							
la alth Daniel	tion Administration					<u></u>			

P.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	·	X3) DATE SURVEY COMPLETED	
		HFD03-0001		B. WING			06/12/2008
NAME OF PE	ROVIDER OR SUPPLIER	 	STREET ADDR	ESS, CITY, STATE	ZIP CODE		
IDI				TON ROAD, S ON, DC 2002		:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S P (EACH CORRECTIVE / REFERENCED TO THE		CROSS- COMPLETE
1 401	accurate implements survey. In addition, facility nurses sough to the survey. 5. The facility's nurs Resident #2 receive every meal and before the dentist's orders. review of Resident # on February 13, 200 frequency of daily or meals and before be Management Care F 2008, indicated staff hygiene PRN." Rev revealed that she tyl before and after breapproximately 8:00 I At approximately 8:00 I At approximately 8:00 I At approximately 2:2 revealed that Reside after lunch while at the LPN stated that day provide tooth brushin order." The QMRP at the dentist's recommitdirect support staff pahift confirmed that the	e feeding process to ation of her POs, prior there was no evidence t clarification of the obsing staff failed to ensid dental care/ oral hypere bedtime in accordance on June 10, 2008, a 42's dental records revise, the dentist increased care to "brush teet"	r to the te that rder prior ure giene after ance with t 2:11 PM, vealed that ted the h after d May 6, ral ation brushed at for bed. the QMRP oral care the qmally a "special ey follow M, a the evening brushed	I 401			
	8:00 PM. There was ensured that Reside at the frequency recide. Facility nurses faurinalysis testing in a follows:	in as approximent and at approximent at a	rsing staff ished daily ntist. #2 for				
eaith Regula TATE FORM	tion Administration		60	ee FLC	2011		If continuation sheet 24 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	E CONSTRUCTION .	COMPLE					
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101				TON ROAD, S						
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I 401	Continued From pa	nge 24		I 401	: 2					
	Resident #2's HMC (updated periodica revealed she had r (UTIs). The HMCF developed a UTI, s shortly after treatment of Resident #2's med been treated with 0 October 12, 2007. to show evidence of the weeks that follow When Interviewed approximately 12:1 standard practice, additional urinalysis the antibiotic treatment to the next document.	28, at 2:52 PM, review CP, dated September 2 ally, through May 6, 200 ecurrent urinary tract in indicated that when she was to have urinally ent with antibiotics, to was effective. Review ical chart revealed that Cipro for a UTI, beginning a follow-up urinallysis was die antibiotic treaton June 11, 2008, at 0 PM, the RN confirmed the client should have a sapproximately 2 - 3 when the was completed. The cords and acknowledged urinallysis was performents after the previous	5, 2007 18), Infections he sis testing ensure of she had ng on orts failed diduring tment. ed that, as had veeks after The RN ged that							
	routine urinalysis to Urinalysis testing of infection, for which treatment. Anothe 2008, indicated that unable to void." He attempt to obtain a 3008, 3 ½ months February, and 7 mourinalysis. 7. Facility nurses femergency room (I within the same dates infections).	ngoing POs included hests performed every 6 in October 10, 2007 included she received antibiotic rate report, dated February the test was cancelled awever, the next docur urine sample was on hafter the failed attempt on this after her last such that the sample was alled to send Resident ER) after experiencing y, in accordance with the protocol. On June 10 ure and neurology	months. dicated an ruary 14, ed - patient nented May 30, in cessful #2 to the 3 seizures heir							
lealth Regula	ation Administration		I	600 · FL	C011	if continue	tion sheet 25 of 39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
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I 401 Co	ntinued From pag	e 25		i 401	· · · · · · · · · · · · · · · · · · ·			
wa cor that 14, probact Teach physics 12 The to the expense of the	s seen by the neuresponding consult she had experie 2008. On June 1 gress notes dated by to back seizure gretol was 6.00 Wysician> and the EThe April 14, 2008 lected 3 seizures elew of the agency realed that if a clie 24 hours, send clie client's records the ER on April 14 confirmed the set residents should be reine a third seamining the seizure mowledged that F	ed, beginning at 3:34 rologist on May 1, 20 altation report form inconced three seizures of 1, 2008, at 2:30 PM, if April 14, 2008 reflects of 30 seconds each NL notified <pre>primal or control of Nursing material Seizure Activity Chebrat that day. At 2:37 First or 15, 2008. At 2:50 izure protocol was cut to the emergency did not, however, reflector 15, 2008. At 2:50 izure protocol was cut be taken to an ER if eizure in one day. After erecord, the RN tesident #2 had not be note with the protocol.</pre>	08. The dicated on April a nursing sted: "3 lab ry care ade aware. ecklist also PM, e Disorder d seizure room." eect a visit PPM, the rrent and they er					
urir Jur #4' 200 infe mg rep up 11: Jar 11, urir tha	nalysis testing in a ne 12, 2008, at 10 s medical chart re 08, a urinalysis test ection. She was the twice daily for 10 orts failed to show urinalysis in the 647 AM, review of 12008 ISP, reveal arry tract infection the after receiving tracting the 12008 ISP, reveal the receiving the 12008 ISP, reveal th	led to refer Resident accordance with order 20 AM, review of Revealed that on Janua at had indicated bacter or except and the prescribed Augm days. Review of her evidence (to date) or months that followed Resident #4's HMCP, incorporated in her Jed that she had recurs (UTIs). The HMCP eatment with antibiotic purinalysis testing to	rs. On sident ry 7, white sident ry 7, white side side side side side side side sid					
lealth Regulation	Administration			00 FI	.C011	: If continual	ion sheet 26 of 39	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD03-0001			A. BUILDING B. WING	PLE CONSTRUCTION	· 	06/12/2008			
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1 401	nurses scheduled with her HMCP. 3521.3 HABILITA Each GHMRP sha assistance to resident is individed. This Statute is not Surveyor: 17815. Based on observation the GHMRP failed received habilitation accordance with the for four of the eight (Residents #1, #2). The finding included. 1. Resident #1 was with a Behavior Statute in a Behavior Statute is not Surveyor: 17815. The finding included in the former provision. Her incorporated one-and 10 PM. The Inbehaviors: physical incorporate incorporated in the behaviors: physical incorporate incorporated in the behaviors: physical incorporate incorporated in the behaviors: physical incorporate incor	as no evidence that fact follow-up urinalysis in a FION AND TRAINING all provide habilitation, to dents in accordance with ual Habilitation Plan. It met as evidenced by: tion, interview and record to ensure that each reson, training and assistance Individual Support Pot residents of the facilite #3 and #5)	raining and h the ord review, sident nce in lan (ISP), y. 31, 2008 art of her eveloped n-one 2008 also en 6 AM targeted y (including	1401	1422 3521.3 This stands of as Metas Wiga, Wi Wiga, Wi	utule w Evidence Ce responsible 158. W15	nse 4. Wz49	7.2208	
	excess of her nutr compliance. The incidents of target evidence that stal Behavior Support a. The psycholog	s to abscond, securing itional recommendation BSP said staff should red behaviors. There w fimplemented Residen Plan (BSP), as follows ist wrote the following isological assessment,	ns and non- ecord all as no it #1's :						
lealth Regul	ation Administration			<u> </u>		<u> </u>			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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.1 422	b. An incident report of the while having her has and reopened an exincident report failed staff intervened in a time of the tantrum. available to verify personal of the tantrum accordance with structure of the tantrum accordance wit	ge 27 It: "Data for February data for March and Aport, dated March 3, 200 at Resident #1 had a tir washed. She fell to kisting sore on her kneed to indicate how or who cordance with the play the cordance with the play to indicate whether the trum behavior had been ategies outlined in the street of admission and May 1, 2008. On was observed ambulated and may 29, 2008, rever custom-molded shoe ankles." On June 12, ualified Mental Retard P) revealed that the techniment for an evaluation of the custom-molded shoe ankles." On June 12, ualified Mental Retard P) revealed that the techniment for an evaluation of the custom-molded shoes, dated May 19, emained without custom-mained	8, at 6:15 cantrum the floor e. The nether an, at the ioral data of the cort, dated e staff's en in BSP. ent #1 had er incident stained on June 9, ing with an he home. therapy ealed a s due to 2008, ation am had tion (i.e. hoes was presented 2008. To	1422	b. Reference respo W436, W153 W149, W249 W240, W252 C. Reference res 1422. b	, W154 , W322	7.23.08 Oncont		

D PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM!	BER: A, BUILI B, WING	3	06/12/2008
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DI			WASHINGTON, DO	THE PROPERTY OF CO	RRECTION (X5) COMPLETE
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1 422	Continued From		1 422	1422, continu	ederi
3. The facility failed to ensure that Resident #2 received training and appropriate staff support in the use of a safety harness. On June 9, 2008,		, 2008,	3. Reference response	onse to 7.23.08	
	i beginning at 200	roximately 11:01 Aivi, c	163Idelit #2	(422.a	Otalons
beginning at approximately 11:01 AM, Resident #2 was observed at her day program. Her right arm and shoulder were positioned outside of the safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot		if the safety ed about the that she		: :	
had repositioned her arm because it was not outdoors. [Note: At the time, the air indoors felt comfortable to this surveyor.] Further interview with the day program staff revealed that her safety			nterview with		
harness should be secured at all times "for protection," to prevent her from leaning too far forward. On June 12, 2008, at 10:43 AM, the QMRP, RN and home manager all concurred that		too far M, the		:	
	Resident #2's sa all times. They	afety harness should be further indicated that the idenendently move her	e secured at ne resident arm out from	:	
	under the harne reviewed this to	ess. The QMRP stated pic with residential states B) training. There was	ff at a recent no evidence,		:
	harness was ke resident was at	ne facility had verified we pt properly secured who day program. In addit the resident's allege	ion, there was d habit of	4	
	removing the st	afety harness had beel siplinary team, to includ	J Sociesseo		:
	an air mattress	failed to ensure that Re		4. Reference Y	response to
home mana		nterdisciplinary team. Interview with the group nome manager on June 11, 2008, at 3:10 PM, revealed a new air mattress had been requisitione for Resident #3 after her previous one was			i !
	for Resident #. discarded (due was no air mat	to a foul odor). At tha	it time, there		·

(X3) DATE SURVEY

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	i	: 	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREE			B. WING	· · · · · · · · · · · · · · · · · · ·		06/1:	2/2008	
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1422	have an air mattre skin breakdown." indicated the mattre and that it should 12, 2008, at 4:15 for a 719A form that wearlier. The home had not yet been stop the primary care possible. The facility fails wheelchair was mobservation of Rewheelchair on Junthe treads on the I very worn. The vitibox was torn and of the right armress observation at 6:5 inches in diameter from which the foaindicated that the repaired approxims survey and that the wheelchair again, was no evidence in to ensure that Resmaintained in good 3523.1 RESIDENT Each GHMRP restricted that the rights of resides the rights of resides.	I a recommendation that is "to assist in the prevente ISP maintenance is ress should be monitored by the ISP maintenance is ress should be monitored by the ISP maintenance is ress should be monitored by the ISP maintenance is replaced as needed. The ISP manager stated that the ISP manager stated in the ISP manager is signature. The ISP maintenance is replaced as they were hysician's signature. The ISP maintenance is replaced as they were hysician's signature. The ISP maintenance is replaced as they were hysician's seated in her they in the edges of the vinyl covering on the ISP may be in the center of the maintenance is resident as exposed. Staff is seat of the resident's chartenance is resident had damage at the time of the surve measures had been imposed at the time of the surve measures had been imposed in the ISP is wheelchair with the ISP is wheelchair with the ISP is a seated in her the ISP is a seated in her the ISP is the ISP is a seated in her the ISP is wheelchair with the ISP is a seated in her the ISP is wheelchair with the ISP is wheelchair with the ISP is a seated in her the ISP is a seated in her the ISP is wheelchair with the ISP is a seated in her the ISP is a seated	ention of schedule ed daily. On June presented 3, 3 weeks he form awaiting ent #5's revealed s were the foot e front end nole (2 to 3 olded seat interview hair was re the dher own ey, there olemented was	1 422	Reference W436 of report		desichency	7.23.08
	and other applicat	n D.C. Law 2-137, this only the District and federal I	aws.	<u>.</u>		· · · · · · · · · · · · · · · · · · ·		
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				A. BUILDIN		(X3) DATE SURVEY COMPLETED
		HFD03-0001		B. WING_		06/12/2008
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I 500	Continued From pag	је 30		I 500	1500	
·	Surveyor: 17815 Based on Interview failed to implement	met as evidenced by: and record review, the policies that ensured of the four residents in to #1 and #2)	the health		This Statute u met as evider	oill be nced by:
	The findings include	: :			:	
	1. Resident #1 was admitted to the facility on January 31, 2008. Her records indicated an history of falls, including "status post fracture of the right humerus." Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, at 4:10 PM, revealed that the resident's previous Behavior Support Plan (BSP) developed by her former provider had incorporated using one-on-one staffing. The QMRP said she had reviewed with her staff the existing BSP at the time of admission. The QMRP further indicated that the resident received one-on-one supervision during awake hours (6 AM - 10 PM). This was verified as in accordance with her updated Individual Support Plan (ISP), dated May 23, 2008.				Reference respons	e to 1422.a 7.23.08
1.	During the first several months after Resident #1 was admitted to the facility, she had four documented falls, some of which resulted in injuries. The survey revealed that the facility had failed to implement a system to effectively prevent Resident #1 from sustaining injuries, as follows: a. An incident report documented that approximately one week after admission, on February 7, 2008, at 3:30 PM, she fell while boarding a van and sustained bruises to her face. The resident's Health Management Care Plan					
Jaalth Dagul	ation Administration					

PRINTED: 07/07/2008 FORM APPROVED

NAME OF PROVIDEN OR SUPPLIER ID 1 SUBSEMENT OF SECURITY, STATE, JP CODE 3028 STANTON ROAD, SE MASHINGTON, DC 20020 PROVIDENCY MATE BE PRECEDED BY FILL RESULATORY OR LOS IDENTIFYING INFORMATION I SOO Continued From page 31 (HMCP), dated February 1, 2008, stated that due to her setzure disorder, she had potential for sustaining injuries. The HMCP instructed staff to implement "fall precautions, daily," however, it did not specify or otherwise describe what fall precautions should be implemented. Be reyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she felt. c. Cross-refer to federal deficiency W252. Another incident report, dated March 3, 2008, at 8:15 PM, documented that Resident #I had a farthrum while having her hair washed. She reportedly felt to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with her BSP. There was no record of the March 3, 2008 behavioral episode in the resident's behavior data. The corresponding investigation report, dated March 10, 2008, failed to indicate whether the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the staffs response to the tantum behavior had been in accordance with the indicated to prevent future incidents. d. Review of in-service training records revealed that on March 21, 2008, th	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE		
IDI SUMMARY STATEMENT OF DEPICENCES WASHINGTON, DC 20020 PROVIDER SUMMARY STATEMENT OF DEPICENCES WASHINGTON, DC 20020 ISON GRACH DEPICENCY MUST BE PRECEDED BY FILL REGULATORY ON LEG CARMITI'M BY ORGANION (RACH DEPICENCY MUST BE PRECEDED BY FILL REGULATORY ON LEG CARMITI'M BY ORGANION I 500 Continued From page 31 I 500 An incident report decumented that on February 10, 2008, stated that due to her secure disported be implemented. b. An incident report documented that on February 10, 2008, at 2:15 PM, Resident #1 fell while getting up from the sofs after awakening from a nap. She sustained slight swelling above her eyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she fell. c. Cross-refer to federal deficiency W252. Another incident report, dated March 3, 2008, at 6:15 PM, documented that Resident #1 had a tantrum while having her hair washed. She reportedly left to the floor and respends an existing socie on her knee. The incident report date on microse how on white floor and respends and existing socie on her knee. The incident report date washed to microse how on white floor and respends and existing socie on her knee. The incident report had bean in accordance with the strategies outlined in the BSP. It should be noted that there was no evidence that the facility determined whether the staff a response to the tentrum behavior had been in accordance with the strategies outlined in the BSP. It should be noted that there was no evidence that the facility determined whether the staff are sponse to the instrument behavior had been in accordance with the strategies outlined in the BSP. It should be noted that there was no evidence that the facility determined whether a deficience of the provided training to the direct support staff no one-on-one duties and responsibilities. However, on March 24, 2008, at 7:55 AM, staff discovered a bruise to		HFD03-0001			3		06/12	/2008
DAY DE CONTINUED TO THE DESTRUCTION OF CORRECTION GRACH CORRECTION CONTINUED TO THE PROPERTY OF DESTRUCTIONS OF THE PROPERTY O	NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
PREPIX (EACH DERICIPION ATTOR PRECEDED BY FULL REQULATORY TAG) Continued From page 31 (HMCP), dated February 1, 2008, stated that due to her seizure disorder, she had potential for sustaining injuries. The HMCP instructed staff to implement "fall precautions, shally," however, it did not specify or otherwise describe what fall precautions, shally, "however, it did not specify or otherwise describe what fall precautions should be implemented. b. An incident report documented that on February 10, 2008, at 2:15 PM, Resident #1 fell while getting up from the soft after awakening from a nap. She sustained slight swelling above her eyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she fell. c. Cross-refer to federal deficiency W252. Another incident report, dated March 3, 2008, at 6:15 PM, documented that Resident #1 had a tantum while having her hair washed. She reportedly fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with her BSP. There was no record of the March 3, 2008 behavioral episode in the resident's behavior data. The corresponding investigation report, dated March 10, 2008, failed to indicate whether the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had been in accordance with the staff's response to the tantrum behavior had	וסו						·	
(HMCP), dated February 1, 2008, stated that due to her seizure disorder, she had potential for sustaining nigniuries. The HMCP instructed staff to implement "fall precautions, daily," however, it did not specify or otherwise describe what fall precautions should be implemented. b. An incident report documented that on February 10, 2008, at 2:15 PM, Resident #1 fell while getting up from the sofa after awakening from a nap. She sustained slight swelling above her eyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she fell. c. Cross-refer to federal deficiency W252. Another incident report, dated March 3, 2008, at 6:15 PM, documented that Resident #1 had a tentrum while having her hair washed. She reportedly fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with the BSP. There was no record of the March 3, 2008 behavioral episode in the resident's behavior data. The corresponding investigation report, dated March 10, 2008, failed to indicate whether the staff's response to the tentrum behavior had been in accordance with the strategles outlined in the BSP. It should be noted that there was no evidence that the facility determined whether additional safety precautions might be indicated to prevent future incidents. d. Review of in-service training records revealed that on March 21, 2008, the QMRP provided training to the direct support staff on one-on-one duties and responsibilities. However, on March 24, 2008, at 7:55 AM, staff discovered a bruise to	PREFIX	(EACH DEFICIENCY MUST	TBE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION	SHOULD BE CROSS-	(X5) COMPLETE DATE
	1 500	(HMCP), dated Feb her seizure disorder sustaining injuries. implement "fall pred not specify or other precautions should b. An incident report 10, 2008, at 2:15 Pl up from the sofa aft sustained slight swe reportedly saw her a unable to reach her c. Cross-refer to fed incident report, date documented that Rehaving her hair was floor and reopened. The Incident report staff intervened in a was no record of the episode in the resid corresponding investigation to the tantrum behawith the strategies of the facility determining recautions might be incidents. d. Review of in-sent that on March 21, 20 training to the direct duties and responsi	ruary 1, 2008, stated in r, she had potential for The HMCP instructed autions, daily," however wise describe what fall be implemented. It documented that on M, Resident #1 fell wher awakening from a relling above her eyebras she was getting up before she fell. Ideral deficiency W252 and March 3, 2008, at 6 and existing sore on he failed to indicate how accordance with her Barren as her was perfect to indicate how accordance with her Barren and the staffs vior had been in accordant whether the staffs vior had been in accordant there was no evided whether additional to indicate to prevent wice training records in 2008, the QMRP provides support staff on one-billities. However, on the staff on one-billities. However, on the staff on one-billities.	February ile getting nap. She ow. Staff but was Another 15 PM, um while ell to the or whether SP. There vioral The March 10, response rdance ence that safety future evealed led on-one March 24,	1 500	C. Cross relievence to W252 of t dehaevery repo	response he federal	7. 22.08

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1 500	e. On April 2, 2008, after her foot reported ambulating. The codated April 6, 2008, PT training. In-servindicated that the P 2008, approximately fall, and after she existed that the P 2008, approximately fall, and after she existed that the P 2008, at approximate heard making "loud Staff entered the best the floor, with an abswellen right ankle. room revealed a right the resident's injuried her March 2008 BSI Plan (ISP), she was supervision during a PM. When interview acknowledged that the time of her injuring. On June 9, 2008 revealed that she was therapist (PT) on Fe assessment report, indicated that she "v molded shoes as so severely pronated all on proper lifting tech	right face, under the was not known. Resident #1 fell on hedly got caught on a corresponding investiga included a recommerice training records, however, and the provided training on the face of the provided training on the sulted in a sprained at documented that on ely 8:00 AM, Resident vocalizations" in her the droom and found her resion to her right knew Evaluation at the emit ankle sprain. The cost were unknown. According and her Individual Storeceive one-on-one wake hours between wed further, the QMRF he resident had been	er knee chair while tion report, ndation for owever, May 17, oril 2, 2008 or fall (on inkle. May 1, t #1 was bedroom. seated on ie, and a ergency origin of cording to iupport e staff 6 AM - 10 origin alone at alone at it's record inysical oos, dary to e trained is onto the	1 500	Cross reference to 1422 a. for 9.	7.23.08 e. f. and
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I 5 00	Continued From page 33 recommendations and clinical plans with the QMRP, House Manager, direct support staff and the relevant interdisciplinary team members on February 29, 2008. However, on June 9, 2008, interview with the QMRP revealed that the PT recommendations had not been achieved timely, as follows:			I 500	1500		
	1) Staff in-service training records indicated that the PT trained staff on May 17, 2008, 2 1/2 months after the assessment and almost 4 1/2 months after she was admitted.			·		: : : :	
	2) The resident remained without the molded shoes. She was scheduled for an appointment on July 10, 2008, 3 1/2 months after the PT assessment. It should be noted that the 719A form for the custom-molded shoes was dated May 19, 2008 more than 2 months after the PT discussed the need for shoes with the QMRP.					; ; ;	
	h. Cross-refer to federal deficiency W153. Staff who were on duty at the time that Resident #1's injuries of unknown origin were discovered on May 1, 2008, at 8:00 AM, failed to implement the facility's incident management policy to ensure timely reporting. The policy states that the QMRP and Director should be notified immediately of all emergencies and it also stated that incident reports should be completed before the end of the shift. However, the QMRP, State agency and the facility's Director of Residential Services were notified more than 24 hours later, on May 2, 2008 (at 8:00 AM, 2:29 PM and 2:50 PM, respectively).				Cross referento W153 Red report, Als response to	eval deficiency o reference 1422. A.	7.23.08 orgoines
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	she had experienced four falls between January 31, 2008 - May 1, 2008. Even though she had one-on-one staff assigned between 6 AM - 10 PM, there were 3 injuries documented since her BSP was updated in March 2008, 2 of which were of unknown origin. In addition, the resident remained without her prescribed custom molded shoes at the time of the survey. There was no evidence that the facility implemented measures timely to ensure the resident's safety.				·			
	2. A mealtime protocol had been developed to address Resident #2's assessed risk of aspiration. Observations at the day program and in the home, however, revealed a failure to protect her health and safety. The mealtime protocol failed to provide clear, written instructions to ensure the resident's health and safety. In addition, staff did not provide the meals in accordance with the protocol, as follows:				·			
		ealtime protocol, dated ovide clear, written ins					:	
,	1) On June 9, 2008, Resident #2 was observed having lunch at her day program. At 11:44 AM, the resident held her WonderFlo spout cup with her right hand and was observed guzzling Boost Plus nutritional supplement at a very fast pace. The resident coughed repeatedly while drinking. At one moment, the staff person told her to "be careful you have to rest, drink a bit, and then rest." The staff person placed her hand behind Resident #2's head, pulled it forward slightly, because the resident had tilted her head backwards, hyperextending her neck. Despite the one verbal prompt, the resident did not slow her drinking pace and the coughing continued. The staff person turned to this surveyor and							
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l 500	Continued From pag	je 35		1 500			;	
	stated "when she puts this cup in her mouth, she doesn't want to release the cup" until it is empty. At 11:54 AM, the resident coughed repeatedly while drinking some apple-cranberry juice at a fast pace. When asked if the resident coughed often, the two direct support staff who were assisting at lunch replied yes.							
	protocol revealed the her with drinking Fallowing her to take and after meal is confurther elaborate on There were no instru	of Resident #2's mealing following: "Staff show of the cup in her right sips of beverage between the protocology of the staff should assigned that addressed for when she drank flood follows that addressed for when she drank flood follows that addressed for when she drank flood following the following that addressed for the following the following the following that addressed for the following the following that addressed for the following the f	uld assist ght hand veen bites ol did not st her. d the					
	following: "feed her aspiration such as eyes." The protocol	ealtime protocol includes slowly; monitor for sig coughing, choking, w did not, however, ins respond if she showe	ns of atery truct staff		·	, , , , , , , , , , , , , , , , , , ,	· · · · · · · · · · · · · · · · · · ·	
	day program nurses staff to bring the res she showed signs o day program case n informed of the obse coughing. They were support staff had incomposed frequent occurrence been told that the result of the case managers group home for furth address her rapid	00 PM, interview with a revealed that they exident to the nurse's start aspiration. The nurse are also informed that they exident that coughing a that they were previous that they were previous that they were previous attact that they would ner clarification on how	pected atlon if ses and a ately be with he direct was a nurse had at lunch. usly ng meals. ask the					
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I 500	Continued From page 36 drinking while hyperextending her neck.		1 500					
,	b. Observations at the day program and in the home revealed staff did not feed Resident #2 foods that were of the consistency ordered by the primary care physician and included in the mealtime protocol, as follows:				; · · · · · · · · · · · · · · · · · · ·			
,	1) On June 9, 2008, at 11:31 AM, Resident #2 presented her lunch plate at the day program. was served, among other food items, pureed be burger with gravy. The burger and gravy was of thin and watery consistency. Her mealtime profindicated that she was to receive foods "pureed added fiber, pudding consistency." This was consistent with her physician's orders, dated Jul 1, 2008 ("pureed to pudding consistency"). It should be noted that the resident repeatedly refused attempts by staff to feed her the food. was presented Boost Plus nutritional supplementated. At approximately 2:05 PM, two day program nutwere informed that Resident #2's food was not pudding consistency, as ordered. The nurses a case manager stated that they would ensure the lunches served in the future would be of the prescribed consistency.		ram. She eed beef was of a ne protocol oureed with vas ted June). It dly ood. She					
			s not of a rses and a ure that		1 	:		
	2) On June 9, 2008, at 6:21 PM, residential staff was observed mixing Resident #2's dinner foods (pureed chicken, green beans and mashed potatoes) together into a wide-rimmed beverage glass. After the resident ate a few spoonfuls of the food mixture, she refused to continue. The staff stirred Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. This too, was not the "pudding" consistency ordered by the primary care physician.							
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1 500	several times while complete description At approximately 6:2 resident's coughing informed her that the of pudding consister c. Staff in the home liquids in the prescrifollows: On June 9, 2008, at person was observed Resident #2's puree prescribed Wonderf was then observed Resident #2's mouth glass. The resident the resident coughe said "good girl" and her mouth. The staff Plus into the glass, soupy texture. Once Resident #2 coughe her bib. The staff scand continued prescribed with that cough, at surveyor summoned The RN, who had not that time, intervenes staff about the residenting, the staff scand continued prescription, the staff scand pointing, the staff scand continued to can of Boost Plus, p	collowed, Resident #2 being fed the mixture in the paragraphs the PPM, the surveyor beto the RN's attention, e resident's food had not. I did not give Resident bed WonderFlo spout 6:24 PM, a direct super did food, instead of using the mixture in from a wide-rimmed its neck was hyperexted. Without pausing, the pouring the mixture in from a wide-rimmed its neck was hyperexted. Without pausing, the pouring the mixture of the feeding resumed the rendered the method and food came and i'l didn't tell you to be the feeding resumed the feeding resumed the mearby RN's attent of the pouring the dinner at a separagraphy in the dinner at a separagraphy. She are ent's WonderFlo cupaid it was in the kitchen, opened a soured it into the spoulent. The resident has	(see at follow). Frought the and not been to take the affinto aff person ato beverage ended and the staff ure into the Boost aixture to a d, e out onto spit it out" fast pace. M, this ention. I meal at sked the While another at cup and	1500								
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R 122	4701.2 BACKGROUND CHECK REQUIREMENT			R 122	R22			
	shall obtain a crimir either obtain or con Columbia Nurse Aid	in section 4701.6, each nal background check, a duct a check of the Dis de Abuse Registry, befo the contract services o	and shall trict of ore					
-	Surveyor: 17815 Based on the review GHMRP failed to er	met as evidenced by: v of personnel records, nsure or obtain criminal prior to employing unli	i . [This Stote	nte will b	e met as	
	beginning at 8:47 A	onnet files on June 11, 2 M, revealed no evidend d check for 1 of the 13	ce of any					
R 125	The criminal backgrowth criminal history of the contract worker for all jurisdictions with employee or contra	JND CHECK REQUIRE round check shall discle he prospective employe the previous seven (7) in which the prospectiv ct worker has worked of years prior to the chec	ose the se or years, in re	R 125	R 125 4701.5 This Stat as eviden	ute will	be met	6 13.08 ongoine
	This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.				as eviden	rced by		OTTES STATES
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LA! ORY		USUPPLIER REPRESENTATIVE	'S SIGNATURE			RS		7/17/08

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	beginning at 8:47 Al comprehensive crim the 13 direct support documented. Howe during 2004 and the	onnel files on June 11, M, revealed no evider ninal background chec rt staff (S4). A DC che ever, she had worked ere was no evidence o	nce of a ck for 1 of eck was in Virginia		Background C of the 13 dire staff (54) wo at the time survey.	heave for l ect support is completed a of the	7.16.08
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ı	This is a repeat defi dated June 14. 200	iciency. See deficiend 7.	cy report			. i	
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